School of Occupational Therapy and Social Work

Vocational Recovery in Mental Illness – The gap between policy and person-centredness

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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature: 

Date: 20th December 2013

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Abstract

People with mental illness have low participation in work. Besides significant health benefits, employment promotes social inclusion for people with mental illness, encouraging meaningful participation in the community, a pathway from welfare and poverty to independence, and a good life.

Vocation has been described as a calling and a means of fulfilment, and personal recovery as the process of transcending symptoms, psychiatric disabilities, and social handicaps, and living life as well as possible. There are well established theories on vocation, as well as recovery from mental illness, however little, if anything is known about *vocational recovery* as a concept. Vocational recovery can be envisaged as a person with mental illness regaining or establishing a range of valued roles associated with vocation as it is broadly defined. This thesis explores how people with mental illness establish and achieve their vocational recovery goals within the context of complex and ever-changing policy and service settings.

The study was completed in three phases, aiming to: 1) explore the vocational experiences of people with mental illness and identify the facilitators and barriers they face in their vocational journeys; 2) develop a definition of vocational recovery and a framework for facilitating vocational recovery for people with mental illness; and 3) describe how local mental health and employment services in Western Australia address vocational recovery.

In Phase One, three focus groups and nine individual in-depth interviews were used to gather information about participants' lived experiences of mental illness, what vocation meant to them, their vocational aspirations, and the facilitators and barriers encountered in their experience of engaging in vocational activities. The participants were adults who were working, seeking work, or preparing to seek work, recruited through mental health and employment services in Western Australia. Interpretive phenomenological analysis revealed five themes and seven subthemes. These themes are: the

personal and social sequelae of mental illness; vocation; barriers to vocation; facilitators to vocation; and vocation in the context of recovery journeys. According to participants, with the onset of mental illness, came a severing from participation in usual occupations, which in turn lead to a loss of a sense of identity. Engaging in vocational activity was a way of establishing or re-establishing oneself, and re-crafting one's identity. The participants described vocation as a calling, encompassing meaningful, enjoyable, purposeful, and productive activity. Personal barriers to vocation included stigma, loss of valued roles, and restrictions in opportunities. Facilitators of vocation were expressed in formal and informal supports. This phase explored the relationship between stigma, occupational justice, and participation in valued roles. The importance of providing recovery-focussed vocational support for mental health service consumers led to the second phase of the study, which explored the concept of vocational recovery in mental illness.

In Phase Two, a two-round Delphi study was conducted in order to develop a definition of vocational recovery and a Framework for Facilitating Vocational Recovery in Mental Illness. Delphi panellists comprised 21 people who identified themselves as mental health service users, mental health professionals, carers and advocates, employers, and policy makers. The Delphi study was conducted online using a survey tool and email correspondence, and through face-to-face interviews. The data were analysed using a thematic analysis and card sort process to group themes. A Framework for Facilitating Vocational Recovery in Mental Illness was developed using an ecological approach in order to organise and interpret the findings. This phase detailed rich understandings of vocation; diversity of views across stakeholder groups about recovery; facilitators and barriers to vocational recovery at individual, social, and service provision and policy levels; and how services can encourage vocational recovery for people with mental illness.

The third phase was a case study that explored how vocational recovery is encouraged or otherwise in Western Australia. Policies, legislation, and guidelines were critically reviewed in order to identify significant policy

initiatives. Five key informants who were service providers that were knowledgeable about local mental health services were interviewed in person or through email. Data were extracted through thematic analysis and cross referencing themes with a review of policy and legislative documents. The findings highlighted challenges to vocational recovery such as marginal employment opportunities and a lack of integration of employment outcomes in recovery-focussed services. Mental health service providers acknowledged the importance of vocational recovery. However, they were not able to advocate for it due to differences in work practices between employment and mental health services.

Vocational recovery is a concept that holds deep personal meaning for people. People with mental illness can regain their self-identity and live good lives through their vocational recovery journeys. However, policy, funding models, and services need to deemphasise economic outcomes, and be more flexible and person-centred in order to truly support people with mental illness in achieving their vocational aspirations.

Table of Contents

List of Figures

List of Tables

List of Definitions

Burden of Disease and Injury – a measure used to assess and compare the relative impact of different diseases and injuries on populations. It quantifies health loss due to disease and injury that remains after treatment, rehabilitation or prevention efforts of the health system and society generally

Comorbidity – the presence of one or more disorders in addition to a primary disease or disorder

Competitive employment – see page 10

Consumer – see page 5

Consumer consultants – are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs

Disability – see page 6

Disability Employment Services (formerly Disability Employment Network) – providers offer a range of services to support individual needs, including:

- help to prepare for work, including training in specific job skills
- job-search support, such as résumé development, training in interview skills, and help in looking for suitable jobs
- support when initially placed into a job, including on-the-job training and co-worker and employer support
- ongoing support in a job if required
- the purchase of vocational training and other employment-related assistance
- access to help with workplace modifications; support services; and Auslan interpreting in the workplace

There are 2 types of Disability Employment Services:

1. Disability Management Services for people with disability, illness, or injury who need the help of an employment service but do not expect to need long-term support in the workplace; and
2. Employment Support Service for people with a permanent disability and with an assessed need for longer term, regular, ongoing support in the workplace

Discrimination – see page 30

Employment – the state of engaging in paid work

Employment consultants – work in Disability Employment Services providers to find suitable employment for job seekers or clients.

Employment services – Agencies that find jobs for people who are seeking them

Impairment – problems in body function or structure such as a significant deviation or loss.

Inclusion – being part of the social, economic, political and cultural systems which contribute to the integration of a person into the community

Individual placement and support – see page 51

Labour force – see page 7

Labour force participation – proportion of working-age persons in an economy who are employed or are unemployed but looking for a job

Mental disorder – see page 3

Mental health services – services that provide treatment, rehabilitation, or community health support targeted towards people with mental illness. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function

Mental health system – see page 12

Mental illness – see page 3

Prevocational Training – an approach in which participants undergo a period of preparation before seeking competitive employment. This could involve either work in a sheltered environment or Clubhouse, or some form of pre-employment training or transitional employment. In Western Australia this is also called supported employment

Psychiatric Rehabilitation – formal principles and active specialised strategies within a mental health service system, and external to the system, that support people with a mental illness to perform the physical, emotional, social, and intellectual skills needed to live, learn, and work in the community.

Recovery – see page 3

Sheltered workshops – organisations or environments that employ people with disabilities separately from others

Social networks – networks of friends, colleagues, and personal contacts that bring about social and interpersonal relationships

Stigma – see page 26

Supported Employment – any approach to vocational rehabilitation that attempts to place clients immediately in competitive employment. This may include a preparation period of less than one month. In Western Australia this is called open employment. See page 10

Unemployment – see page 7

Vocation – see page 2

Vocational Recovery – see page 127

Work – a job or activity that a person does regularly especially in order to earn money

Abbreviations and Acronyms

DEN – Disability Employment Network

DES – Disability Employment Services

DEEWR – Department of Education, Employment and Workforce Relations

DoHA – Department of Health and Ageing

DSM-5 – 5th edition of the Diagnostic and Statistical Manual of Mental Disorders

FaHCSIA – Department of Families, Housing, Community Services and Indigenous Affairs

ICD-10 – 10th edition of the International Statistical Classification of Diseases and Related Health Problems

IPA – Interpretive Phenomenological Analysis

IPS – Individual Placement and Support

K10 – Kessler Psychological Distress Scale

OECD – Organisation for Economic Co-operation and Development

PHaMs – Personal Helpers and Mentors

Chapter 1: Context of the Study

1.1 Introduction

People with mental illness have the capacity and desire to participate in vocational activities such as meaningful work and employment (National Mental Health Commission, 2012), and by doing so benefit from financial security and good mental health. Employment encourages and enables friendships, personal contacts, and social networks; promotes inclusion and fair access; and helps to give meaning and purpose beyond financial and material reward. All of these contribute to and help support recovery in mental illness (Commonwealth of Australia, 2013; Mental Health Coordinating Council, 2008). However, in Australia, there are low labour force participation rates among people with mental illness due to barriers they face in engaging in work. According to the Australian Bureau of Statistics (2004), the labour force participation rate for people with mental illness was 28.2%, which was low in comparison to the rate for people with no disability or mental illness (80.6%). Besides personal factors related to having mental illness, other barriers to labour force participation include stigma and discrimination expressed by employers, which make them reluctant to hire people with mental illness; fear of failure and loss of entitlements such as pensions and allowances by people with mental illness; and inflexible workplaces that do not accommodate the needs associated with mental illness (Merton & Bateman, 2007; Waghorn & Lloyd, 2005).

Over the last 20 years, there has been a growing body of evidence in support of employment services that provide individual placement and support (IPS) for people with mental illness internationally (Bond, 2004; Bond, Drake, & Becker, 2008; Burns et al., 2007; Crowther, Marshall, Bond, & Huxley, 2001; Dixon et al., 2010; Heffernan & Pilkington, 2011; Latimer et al., 2006; Twamley, Narvaez, Becker, Bartels, & Jeste, 2008). According to Bond (1998), the core principles of IPS include competitive employment as a goal, rapid job search, integration of rehabilitation and mental health services, attention to consumer preferences,

continuous and comprehensive assessment and time-unlimited support. In Australia the provision of IPS is complicated by the separation of employment experts from clinical services. Specifically, a person with mental illness may receive separate support from mental health services and Disability Employment Services (DES). This means that employment consultants are completely separate from clinical services and are not part of the mental health team. This arrangement of services limits the adoption of best practice, such as the Becker-Drake IPS model of supported employment (Drake & Becker, 1996), and a recovery-oriented, person-centred approach to vocation.

This thesis aims to contribute to current understandings of recovery in mental illness. This is accomplished by exploring how people with mental illness pursue their desired vocations throughout their recovery journeys. The thesis focuses on describing and theorising vocational recovery, as well as outlining how people with mental illness plan and achieve (or not) their vocational recovery goals. It also examines and critiques how services in Western Australia assist people in their vocational recovery journeys. The primary focus of the study was to ascertain how people with mental illness establish and achieve their vocational goals within the context of recovery, specifically in the area of competitive employment in the labour force. The key words, namely vocation, recovery, and mental illness, which are embedded in the focus of this study, are defined in this chapter. An overview of international, national, and local workforce participation, policies, and practices are provided, along with details of the scope of the study.

1.2 Definitions

1.2.1 Vocation and Recovery

The two key concepts on which this thesis is based are vocation and recovery. These concepts will be developed in detail in Chapter Two, Chapter Four and Chapter Five of this thesis. By introduction here, vocation is defined as meaningful and/or purposeful work or education as chosen and expressed by a

person. It may be paid or unpaid, with volunteering also located within this broad definition. This broad meaning of vocation was captured in the work of Bloland and Walker (1981), who described vocation as not just a function by which one earns a living, but as "a means for fulfilment and a way of existing in the world" (p.199).

A second concept that is central to this thesis is that of recovery. There are varied and complex descriptions of recovery in mental illness in the literature, discussed in more detail in Chapter Two. In essence, it is a personal process of living a good life, even with symptoms of mental illness. A well acknowledged definition of recovery is:

> A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993, p. 159).

A more comprehensive list of definitions is provided at the end of this chapter.

1.2.2 Definition of mental illness

In order to understand the impact mental illness has on people's lives, the following brief review outlines the major features of the illness. Mental disorders are defined by the World Health Organization (2001) as a broad range of conditions that are "characterised by alterations in thinking, mood (emotions) or behaviour associated with personal distress and/or impaired functioning" (p.21). The Australian National Mental Health Commission (2012) defined mental illness as "disturbances of mood or thought that can affect behaviour and distress the person or those around them, so the person has trouble functioning normally" (p.76). According to the World Health Organisation, more the 450 million people across the world have mental

illness. Of these, an estimated 151 million people have been diagnosed with depression and 26 million people with schizophrenia (World Health Organization, 2009).

In this thesis, the term mental illness is used interchangeably with mental disorder to mean a range of mental and behavioural disorders that fall within the 10th edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (World Health Organization, 2004) and the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) . These two main systems of classification for psychiatric diagnoses were developed by the World Health Organisation and the American Psychiatric Association respectively in collaboration with mental health professionals. The purpose of these classification systems are to: "distinguish one psychiatric diagnosis from another, so that clinicians can offer the most effective treatment; to provide a common language among health care professionals; and to explore the still unknown causes of many mental disorders" (Sadock & Sadock, 2007, p. 284). These two systems are not fully aligned approaches; however, both are used in service systems in Western Australia. In this thesis, people with mental illness who had been diagnosed according to these classification systems (or previous editions of these) were recruited as participants through the health services they used. As mental illness is a contested concept (Herron & Mortimer, 1999), the working definition of mental illness used in this thesis focuses on the diagnosis approach used by these services. The range of mental disorders participants with lived experience of mental illness were diagnosed with included depression, bipolar affective disorder, schizophrenia, anxiety disorders, and substance use disorders. Intellectual disabilities and developmental disorders were not explored in this research.

1.3 Overview of mental illness in Australia

In Australia, mental illness is diagnosed according to the conventions used in psychiatry. Although people with mental illness are still generally referred to as patients or clients in clinical settings, the most accepted recovery-based term for a person who has used, is using, or might use mental health and related human services is a *consumer* (Mclnerney, 2008). This term may be used in different contexts to refer to both people with mental illness and carers of people with mental illness; however, in this thesis a consumer refers solely to a user of mental health services. The term consumer is aligned with the modern mental health consumer movement (or user or survivor movement), which developed during the 1970s and 1980s (Chamberlin, 1990). Since then, there has been a growing recognition of the need to increase the involvement of consumers in decision making regarding their own health care, or at least provide them with the opportunity to do so. In Australia, it is common practice for mental health services to employ consumer consultants to be involved in service planning, delivery, and evaluation (Bennetts, Cross, & Bloomer, 2011; Bennetts, Pinches, Paluch, & Fossey, 2013).

An estimated seven million Australians, or 45% of the adult population, will experience a mental disorder over their lifetime (Australian Bureau of Statistics, 2008). The 2007 National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics found that 20% of the population aged between 16 and 85 years had a mental disorder in the twelve months prior to the survey (Australian Bureau of Statistics, 2008). In the 2011-2013 Australian Health Survey, 13.6% of Australians reported having a long-term mental or behavioural condition. These comprise a range of organic and psychological conditions such as depression, anxiety disorders, dementia, and substance abuse (Australian Bureau of Statistics, 2012). The same survey found that about one in ten adults experienced high or very high levels of psychological distress, as measured using the Kessler Psychological Distress Scale (K10)(Australian Bureau of Statistics, 2012).

Disability can be described as an impairment in body structure or function, a limitation in activities, or a restriction in participation (Australian Institute of Health and Welfare, 2008). The impact of disability is measured as burden of disease. According to the Burden of Disease and Injury in Australia study, mental disorders accounted for an estimated 24% of the total years lost due to disability (disability-adjusted life years), and were the leading cause of disability burden in Australia (Begg et al., 2007). Disability-adjusted life years is the measure used in describing the sum of potential years of life lost due to premature mortality and the years of productive life lost due to disability. Anxiety, depression, personality disorders, and alcohol abuse constituted the major part of the burden (Begg et al., 2007).

In Western Australia, people with mental illness are disadvantaged in comparison to people without disability. A recent study of 1,825 participants showed that people with mental illness experienced higher rates of financial difficulties (42.7%), loneliness and social isolation (37.2%), unemployment (35.1%), poor physical health and disease (27.4%), uncontrollable symptoms of mental illness (25.7%), lack of housing (18.1%), stigma and discrimination (11.6%), and lack of family or carers (6.2%) (Morgan et al., 2012).

People with mental illness may experience other disabilities and illnesses, which may pose additional barriers to their participation in valued activities. Forty-three per cent of people with a physical disability also experience long-term mental illness as a comorbid disorder (Australian Bureau of Statistics, 2008). Whist this report did not comment on the comorbidity of mental illness with other kinds of disabilities, such as acquired brain injury or intellectual disability, having a comorbid disorder can compound upon the negative experiences of a person with mental illness. This comorbidity restricts their ability to participate in activities of daily living, such as self-care tasks, accessing the community, and participating in valued undertakings far more than if they had a single disease or disorder. It also hampers vocational-based activities such as schooling and employment (Australian Bureau of Statistics, 2008).

1.4 Labour force participation

People with mental illness are among the most socially and economically marginalised members of the Australian society, experiencing high levels of unemployment and non-participation in the labour force. Data about the numbers of people who engage in paid work is expressed in the literature in terms of unemployment rates and work force or labour force participation. In this thesis, labour force is defined according to the Australian Bureau of Statistics (2008) as a collective view of persons over the age of 15 who were employed and unemployed (and are able to work). People who are not participating in the labour force are not economically active (Australian Bureau of Statistics, 2008). According to the Australian Bureau of Statistics (2008), the unemployed refer to:

> People aged 15 years and over who were not employed during the reference week, and:
>
> - had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week and were available for work in the reference week; or
> - were waiting to start a new job within four weeks from the end of the reference week and could have started in the reference week if the job had been available then (p. 97).

This predetermined way of defining unemployment poses difficulties for people with mental illness, who may require longer periods of time to obtain work.

In the past, high unemployment rates of between 80 and 92% have been reported for people with mental illness overseas (Auerbach & Richardson, 2005; Blankertz & Robinson, 1996; Harnois & Gabriel, 2002; World Health Organisation, 2000). An estimate of employment rates for people with mental illness was made from data from national surveys in America by Mechanic, Bilder, and McAlpine (2002). They found that about half of the population of people with mental illness and 20% of people with more serious mental illness,

such as schizophrenia were gainfully employed. In Europe, employment rates of people with schizophrenia were 21.5% as compared to 71% in the general population (Marwaha et al., 2007). More recently, these employment figures have improved, with an international review on mental disorders and work reporting that most people with mental illness work. The employment rates in this review were between 55 and 70%. This was about 10 to 15% lower than the rates for people without mental illness (Organisation for Economic Co-operation and Development, 2012).

In Australia, there are low labour force participation rates for people with mental illness (Waghorn, Chant, & Lloyd, 2006; Waghorn, Chant, Lloyd, & Harris, 2011; Waghorn et al., 2012). Employment rates for mental health consumers in Australia have remained at 22% with no improvement since 1999 (Waghorn et al., 2012). Australia is ranked among the lowest of all Organisation for Economic Co-operation and Development (OECD) countries for labour force participation by people with disability, including those with mental illness (Mental Illness Fellowship of Australia, 2010). According to the Australian Bureau of Statistics (2004), the workforce participation rate for people with mental illness was 28.2%, which was low in comparison to the rate for people with no disability or mental illness (80.6%) and people with a physical disability (48.3%) (while this figure is now dated it gives some idea of the extent of the problem).

While approximately three quarters of people with serious mental illness are typically excluded from the workforce (Waghorn et al., 2012), the evidence is that the majority want to work and that they can work when evidence-based services are in place (Waghorn, Lloyd, & Harris, 2009). Obtaining a job involves multiple planning and decision-making processes which may be challenging for people with mental illness. However, research has shown that systemic issues such as mental health policies (Crosbie, 2009) and employment or vocational service characteristics pose a far greater barrier than the characteristics of people with mental illness (Bond, 2004; Bond et al., 2008). In 2012, an OECD report described evidence that:

> Questions some of the myths and taboos around mental ill-health and work. People with a severe mental disorder are too often too far away from the labour market, and need help to find sustainable employment. The majority of people with a common mental disorder, however, are employed but struggling in their jobs. Neither are they receiving any treatment nor any supports in the workplace, thus being at high risk of job loss and permanent labour market exclusion. This implies a need for policy to shift away from severe to common mental disorders and sub-threshold conditions; away from a focus on inactive people to more focus on those employed; and away from reactive to preventative strategies (Organisation for Economic Co-operation and Development, 2012, p. 199).

The systemic barriers within a Western Australian context are explored in Chapter Six and specific program characteristics of Western Australian services are discussed in detail in Chapter Two.

1.5 Policies and practices that support vocation for people with mental illness

1.5.1 International perspective

According to the Universal Declaration of Human Rights, Article 23, "everyone has a right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment" (United Nations General Assembly, 1948, p. 3). This is a powerful statement that classifies employment as important enough to be protected as a basic human right.

Vocational services assist people with disabilities or injuries to return to work activities or participate in the workforce. With regards to vocational services, there are four main types of programs for people with mental illness. The first is a stepwise approach that focuses on training participants to develop specific skills in work readiness activities before placing them into positions (Blankertz

& Robinson, 1996; Bozzer, Samsom, & Anson, 1999; Corrigan, 2001). The notion of readiness is fundamental to the gradualist approach of psychiatric rehabilitation. Gradualism emphasises positive experiences and successes in programs, with slow and gradual development of experiences in order to build a person's self-confidence and coping abilities (Dincin, 1975). Train, then place programs come in many forms, including hospital-based programs, sheltered workshops, enclaves, transition programs, volunteer placements, and clubhouses (Boardman, Grove, Perkins, & Shepherd, 2003; Creegan & Williams, 1997; Lehman, 1995; O'Flynn, 2001). These programs are generally part of traditional psychiatric rehabilitation, and are all considered to be a helpful or even necessary prevocational activity to prepare people with mental illness for competitive employment in the open market (Crowther et al., 2001; Waghorn & Lloyd, 2005).

The second approach is an evidence-based model that supports placing the person with mental illness in real work situations prior to offering them training in order to promote the achievement of their vocational and community participation goals. This place, then train approach is known as supported employment, which has been defined as:

> typically provid[ing] individual placements in competitive employment – that is, community jobs paying at least minimum wage that any person can apply for – in accord with client choices and capabilities, without requiring extended prevocational training… They actively facilitate job acquisition, often sending staff to accompany clients on interviews, and they provide ongoing support once the client is employed (Bond, et al., 2001).

This approach is explored in further detail in Chapter Two of this thesis where the implications of supported employment for people with mental illness are discussed.

A third approach, the social enterprise model, is positioned between the aforementioned models and was developed in the disability sector. These

social enterprises are businesses that are created with the purpose of employing people with disability under the same working conditions as any other business and providing a needed product or service to the community. These working arrangements have been used as an alternative employment pathway to offer paid employment for people with mental illness (Righetti, 1994; Svanberg, Gumley, & Wilson, 2010).

The fourth approach involves unpaid work arrangements. Volunteering is defined as:

> an activity which takes place through not-for-profit organisations or projects and is undertaken:
>
> - to be of benefit to the community;
> - of the volunteer's own free will and without coercion;
> - for no financial payment;
> - and in designated volunteer positions only (Volunteering Australia, 2001, p. 2)

An example of a volunteering program for people with mental illness is inclusive volunteering, which has been shown to be effective in supporting consumers finding and maintaining volunteering roles in the community (Miller, Schleien, Brooke, Frisoli, & Brooks III, 2005).

These vocational approaches and their associated services are often not mutually exclusive for service users, in that consumers may use more than one service concurrently. Furthermore, inconsistencies in terminology and variations in vocational services exist in different countries that employ these approaches. This makes it difficult for stakeholders to make direct comparisons and to understand the types and combinations of services that are most effective for people with mental illness (Corbiere & Lecomte, 2009).

1.5.2 Australian perspective

In Australia, the mental health system comprises: "services and programs in which the primary function is to provide promotion, early intervention, medical and psychiatric treatments and recovery support for people who experience mental health issues or mental illness, and/or their families, carers and support networks" (Commonwealth of Australia, 2013, p. 1). Mental health services are typically funded and delivered separately from employment services (Browne, Stephenson, Wright & Waghorn, 2009; Killackey & Waghorn, 2008). There has been a climate of constant change regarding mental health, disability, and employment policies. Although this tension is explored in detail in Chapter Six of this thesis, as an introduction policy and services that relate to vocation are summarised in this section.

Mental health services in Australia have not been well funded by the government. The 2004 National Mental Health Report described a shortfall of 8.6% in the national spending on mental health (Mental Health Council of Australia, 2005). However, since then, in conjunction with mental health reform, the Australian Government committed $1.9 billion over five years to the improvement of mental health services (Australia Government Department of Health and Ageing, 2006). In the 2011-2012 budget, a further $2.2 billion of funding (a combination of the 2011-12 *Delivering National Mental Health Reform* budget package and the 2010 budget and election commitments) was allocated to mental health services over a period of five years (Australia Government Department of Health and Ageing, 2011), indicating a realisation of the need to respond to the growing burden of mental health in the community.

In the Australian context, addressing employment outcomes for people with mental illness has become a major focus of health policy and funding. Since the Disability Employment Network (DEN) 2006-2009 funding deed (Department of Employment and Workplace Relations, 2007), there has been a strong emphasis by policy makers on employment services for people with disabilities to produce employment outcomes evaluated by the hours worked,

job tenure, and wages earned of consumers. The DES performance frameworks remain focussed on these employment outcomes. However, in 2013, a review was undertaken with key stakeholders, and the performance framework was modified to "give appropriate incentives for providers to place more participants into long-term sustainable employment, deliver a better service for employers and people with disability and focus on continuous improvement" (Department of Education, Employment and Workplace Relations, 2013). The House of Representatives Standing Committee on Education and Employment report: *Work Wanted – Mental health and workforce participation* (2012) made recommendations about ways to enhance education, training, and employment opportunities for people with mental illness. In this report, recommendations were made regarding the achievement of qualitative, as well as quantitative outcomes for people with mental illness. In response to this, the government gave assurances that it would continue to focus on providing incentives for sustainable employment outcomes with a greater focus on quality (Department of Education, Employment and Workplace Relations, 2013).

Various service models are used in Western Australia to provide vocational rehabilitation for people with mental illness. These include approaches that use employment readiness, supported employment, and social enterprise models. Australian Business Enterprises, which were previously called business services are commercial enterprises that enable people with disability to engage in work in a sheltered workshop-type system, where segregated employment involves repetitive and monotonous work such as packaging and assembly. In Australia, this type of service model is confusingly known as *supported employment*.

A second model, often offered through clubhouses is transitional employment. This approach focusses on building vocational skills through part-time entry level positions that are available to members temporarily for 6 – 9 months. Within this model, the job usually belongs to the vocational agency or clubhouse, and employees are perceived as interchangeable

(Marrone, 1993; Marrone, Balze & Gold, 1995). Volunteer work has also been acknowledged as a purposeful activity that promotes community integration and the learning of valuable work skills (Young, 2008). Social enterprises are an alternative to the readiness models, and DES provide employment assistance in the competitive market.

Due to the separate funding and service provision of mental health and vocational services, DES have not been able to easily develop fidelity with the evidence-based IPS model. According to Waghorn, Childs, Hampton, Gladman, Greves & Bowman (2012), since 2006 there have been about 30 successful formal partnerships that have been developed in order to trial the integration of employment specialists into mental health service teams in Australia. Although these early successful partnerships offer promise in improving sustainable employment outcomes for people with mental illness, integration between mental health services and DES has not occurred in Western Australia. Chapter Six of this thesis provides further details of the separation of services and how it affects vocational recovery in mental illness in Western Australia.

King et al. (2006) recommended integrating clinical, vocational, and educational services by enhancing the intersectoral links between services and collocating employment specialists within community mental health teams in order to allow greater communication and coordination of clinical care with vocational goals. However, the Australian system does not easily lend itself to IPS due to different funding models across services and the delivery of DES being outsourced to a variety of organisations. Rose and Harris (2005) identified structural and attitudinal barriers as challenges for people with mental illness in Australia. They suggested that given the health benefits of employment, mental health service providers needed to link to a much greater extent with the providers of employment programs to better meet the needs of mental health consumers. Besides these limitations, other reported barriers to vocational recovery have been stigma, service system issues, welfare policies and benefit schemes (Henry & Lucca, 2004; Sweeney & Kisely, 2003), and the

beliefs of some service providers and families that employment may create undue stress and negative effects (Marrone, Gandolfo, Gold, & Hoff, 1998).

In a ten year study, McHugo et al. (2012) found that people with comorbid severe mental illness and substance use disorders achieved independent housing and stable remission of substance use disorders when they had steady employment. They found that stable employment fostered better quality of life in the first five years, with both steady workers and non-workers having similar improvements at the end of ten years. Although work has been documented to play an important role in recovery as a means of self-empowerment (Provencher, Gregg, Mead, & Mueser, 2002; Strong, 1998; Young & Ensing, 1999) and self-actualisation (Provencher et al., 2002) people with mental illness may have difficulties negotiating the current vocational service system due to the complex overlaps in services and the lack of clear pathways. This topic is discussed in more depth and through the eyes of mental health consumers in Chapter Four where I report data collected from mental health consumers.

In order to improve vocational outcomes, "understanding what is really happening to those who engage in work can be increased by understanding the people who do not fit the statistical norm as well as those who do" (Honey, 2000, p. 273). This study provides formative information on what needs to be addressed in order to bring about improvements in vocational service provision for people with mental illness with a broader focus on quality of life, recovery, and vocational journeys. Consultation with consumers is likely to increase the success of vocational programs, but few studies have focussed on consumers' own experiences and opinions in the Australian context. The research is significant and innovative as it addresses the traditional power imbalances between service providers and a group of mental health consumers by giving them a voice. It also describes what vocational recovery in mental illness is from the perspectives of consumers, educators, and service providers. These different perspectives capture the current climate of contention regarding recovery language, principles, and practices, where differing views

affect the lived experiences of vocational recovery in mental illness for consumers. The research also provides recommendations about how policy and practice may best support vocational recovery in mental illness in the Western Australian context.

1.6 Aim of the study and research questions

The overall aim of the research was to ascertain how people with mental illness establish and achieve their vocational goals within the context of recovery. Specifically, the research methods were developed to address the following questions:

1. What does vocation mean for people with mental illness and what are their vocational aspirations and experiences?
2. What facilitators and barriers do people with mental illness experience in their vocational journeys and how do these impact on paths and services chosen?
3. How does vocation fit into current understandings of recovery and how may vocational recovery in mental illness be described from the perspective of key stakeholders?
4. How do local mental health and employment services in Western Australia address vocational recovery?

1.7 Structure of the thesis

This section provides a brief outline of what is contained in each chapter of this thesis. The research this thesis presents was iterative and had an emergent design, with each of the three phases building upon the one before. This thesis is presented conventionally in order to organise the findings in a logical manner, but in reality the research and its objectives changed over the course of the project. In order to answer the abovementioned research questions, the thesis has been set out in seven chapters. The present chapter has introduced

the research topic, situated the research questions in a specific context, and provided definitions of key terms used in this thesis. In addition to the key terms, a list of additional definitions is provided (in the foreword section of this thesis).

Chapter Two, titled *Mental Illness, Recovery, and Vocation* reviews the related literature on mental illness, recovery in mental illness, and vocation. Theories about occupational justice and ecological systems are applied to these three bodies of knowledge, which are then integrated and presented together in a review of literature. For the purpose of the study, I have selected literature that pertains to Western society as this is most relevant to the research which is set in Western Australia.

Chapter Three, titled *Methodological Design of the Study* presents the overarching methodological perspectives of the research and provides an overview of the methods used in the three phases of this study. This chapter includes a discussion of how I ensured quality of the research in terms of methodological and interpretive rigour.

The three discrete phases of this research are located in Chapters Four, Five, and Six. Chapter Four is titled *An Exploration of Vocational Experiences of People with Mental Illness.* It presents the findings from a focus group and in-depth interviews that explored what vocation means for a group of people with mental illness and the facilitators and barriers they encounter in their vocational journeys. During the development of the research proposal, it was envisaged that this research would be a longitudinal phenomenological study of the vocational journeys of people with mental illness. Objectives One and Two address this original aim. However, a theme that had not been anticipated emerged from Phase One that led me to question how vocation fitted with the domains of recovery. In consultation with my supervisors, and with approval from the Human Research Ethics Committee, I modified the second phase to explore vocational recovery in mental illness. Objectives Three and Four reflect these emergent concerns. Chapter Five, titled

Generating a Framework for Facilitating Vocational Recovery focuses on the themes that emerged from a Delphi study that was conducted in the second phase of this research. Vocational recovery was defined and an ecological model was used to categorise the themes and develop a Framework for Facilitating Vocational Recovery in Mental Illness. Following this phase, I had intended to explore how vocational recovery in mental illness was operationalised using a multiple descriptive case study method in various local vocational services. However, it was a time of change, where many employment services lost funding, and could not be involved in the project. Instead, in consultation with my supervisors, I decided to take a snapshot of what was occurring in Western Australia with regards to vocational recovery. Chapter Six, titled *The Challenges of Implementing Vocational Recovery in Practice* is a case study that examines the themes that emerged from analysis of policy, service, and research documents pertaining to vocational recovery in mental illness in Western Australia. This chapter presents the case analysis of these themes, as well as those that emerged from face-to-face interviews with key informants relating to vocational recovery in mental illness in the local context. In Chapter Seven, I offer concluding remarks for this thesis and detail recommendations for future research and practice.

Chapter 2: Mental Illness, Recovery, and Vocation

2.1 Introduction

This chapter is organised into four main sections that review the literature surrounding mental illness, recovery, and vocation. In the first section, I summarise how mental illness has been understood through history, by focussing on the issues faced by people in a Western societal context. The second section describes the history of the recovery philosophy and service response and how it is used as a guiding principle for contemporary mental health services. This section highlights how lack of clarity exists regarding definitions and understandings of recovery, which is reflected in the current climate of disconnect and fragmentation of service provision. This is a point I return to later in the thesis, particularly in Chapters Five and Six. In the third section, literature about vocation is reviewed in order to discuss the theoretical and practical applicability of this body of work to the thesis topic. The fourth section continues in this vein by detailing the current research, which covers vocation for people with mental illness, focussing on employment and mental health. While much of this literature is still nascent, the intention is to outline the theoretical assumptions surrounding both vocation and recovery in the existing fields of knowledge so that the concept of vocational recovery further developed.

2.2 Mental Illness

The treatment of mental illness has undergone paradigm shifts through the years, with early attempts at treatment dating back to 5000 BC (Porter, 2002). This historical overview focuses on Western societies (such as the United States, Canada, the United Kingdom, European countries and Australia) and details how mental illness has been understood over the last 400 years, incorporating the different ideologies and health service models that have emerged in responding to people with mental illness. The assumptions about the causality and nature of mental illness broadly align with the models of care

of a particular era. On a historical continuum, mental problems have been attributed to the supernatural, moral degeneracy, illness, and disability, and as the understanding of causality has developed, so has the influence and involvement of mental health service users in their own care. Although there has been a movement towards recovery and a person-centred approach to care and service provision, residues of earlier notions (such as social control) tend to persist as more progressive understandings emerge. Thus, conflicting ideas that drive policy and services may be present at one time.

People with mental illness have been vulnerable to social devaluation and stigmatisation in the past. This stigmatisation still exists to a lesser extent in today's society. They have suffered from social control and marginalisation, often due to poor treatment and lack of proper care. There have been inadequate levels of funding for institutional care, community-based mental health, and welfare services. The section concludes by detailing the main issues people with mental illness face in everyday life. This context provides a broad background to the challenges and barriers faced by people with mental illness in securing and maintaining meaningful and rewarding employment, which I describe in Chapter Four through the reports of study participants.

2.2.1 The history of mental illness

Historically, it was common in Western society for people with mental illness to suffer ill treatment and social exclusion (Morrall & Hazelton, 2000). Porter (1987) wrote about this imbalance of power: "the history of mental illness is the history of power… It requires power to control it. Threatening the normal structures of authority, insanity is engaged in an endless dialogue… about power" (p. 39).

Prior to the eighteenth century, mental illness was known as *lunacy* and not considered a medical condition. Rather, there was a commonly held belief that lunatics were possessed by the devil. People who suffered from seizures and apparent mental illness were cared for and controlled by family members, or if

they were turned out by kin, they would become *village idiots* who wandered the roads (Shorter & Marshall, 1997). Lunatics were treated similarly to deviants, with only the most violent and troublesome cases confined in a local gaol (Scull, 1975). Families were held responsible to care for their own, and typical home treatment involved individuals being tethered, beaten, or neglected (Shorter & Marshall, 1997).

The early seventeenth century saw the beginning of the *Great Confinement* (Foucault, 1965, p. 48), a regime of confining problem people such as lunatics, beggars, vagrants, criminals, prostitutes, the old, and the lame in institutions in order to sequester them away from normal citizens (Porter, 1987). The medical focus of mental illness developed during the period of Enlightenment in what has been referred to as the age of reason in Europe. Through the eighteenth and nineteenth centuries, in Europe, America, and Australia, specific institutions emerged to deal with the insane as a separate category of illness. Early examples of these were the Bethlem Hospital in London, and private madhouses belonging to doctors or clergymen, where people with mental illness could live and be supervised (Parry-Jones, 1992). This movement of people with mental illness from gaols to asylums was called the first *psychiatric revolution* (Scull, 1981b). In the absence of official regulation, confinement of people with mental illness in *petites maisons* in France and *madhouses* in England was ad hoc and unsystematic (Scull, 2011). The growth of the number of institutions devoted to the confinement of the mentally ill was closely matched by the opportunities for experimenting with techniques that elicited fear, awe, and dread in the management of people within the institutions (Scull, 2011). People with mental illness were viewed as suffering from *moral degeneracy* (Nolan, 2000, p. 8) and risked being locked away from society for years.

> The enterprise of the age of reason, gaining authority from the mid-seventeenth century onward, was to criticise, condemn and crush whatever its protagonists considered to be foolish or unreasonable… And all that was so labelled could be deemed inimical to society or the

> state – indeed could be regarded as a menace to the proper workings of an orderly, efficient, progressive, rational society (Porter, 1987, p. 14).

By the end of the eighteenth century, reformists, such as Philippe Pinel who was a French physician and William Tuke, an English philanthropist, developed a more benevolent approach – moral treatments that emphasised kindness and empathy as therapeutic efforts to affect the patient's psychology (Carlson & Dain, 1960; Dain, 1976; Roberts & Farris Kurtz, 1987). These treatments were intended to restore mentally ill patients to themselves and they marked the beginning of a modern approach to caring for people with mental illness. However,

> This movement aimed in effect to revive the dormant humanity of the mad, by treating them as endowed with a residuum at least of normal emotions, still capable of excitation and training… They needed to be treated essentially like children, who required a stiff dose of rigorous discipline, rectification and retraining in thinking and training (Porter, 1987, p. 19).

Residents of the asylums were expected to work as part of institutional life, and work programs supported the economy of the institutions. According to the theory of asylumdom, in removing the insane from their harmful environments, and placing them in the appropriate environment of the asylum, they could be re-educated to acceptable behaviour, self-control, and work ethic. The insane could then be rehabilitated back into society, and the workforce (Mellett, 1982, p. 4). Institutions introduced forms of work, like factories "for social improvement … an environment in which social organisation and change are reflexively engineered, both as a backdrop to individual life and medium for the restoration of individual identity" (Wedgewood, in McKendrick, 1961, p. 46). During the late 19th and early 20th centuries, work played a central role in moral treatment, and forerunners of occupational therapy, Dunton, Tracy, Slagle, Major, and Barton began to use

occupation in craft as work projects in order to restore health in invalids (Harvey-Krefting, 1985).

Moral management programs in public institutions gradually developed to include individualised treatment, occupations, and education (Bucknill & Tuke, 1879). However, by the end of the 19th and into the 20th century, these programs declined due to racial tensions between staff and patients with increased migration, high costs, overcrowding, lack of staff, and the emergence of biomedical methods (Dain, in Bing, 1981).

Moral treatment has been criticised as another form of oppression and social control of people with mental illness. According to Foucault (1965), the moral asylum was "not a free realm of observation, diagnosis, and therapeutics; it is a juridical space where one is accused, judged, and condemned…" (p. 269).

2.2.2 Deinstitutionalisation

Asylumdom continued until the late twentieth century, when caring for people with mental illness in long-stay institutions was minimised, and replaced with community care provided by outpatient agencies in a process called deinstitutionalisation (Bachrach, 1996b). This shift towards community care was based on values such as being more inclusive, tolerant, and emancipating for people with mental illness (Johnson, 1990; Scull, 1981a, 1981b). Besides this values base, the deinstitutionalisation movement was also hastened in the 1960s by the introduction of psychotropic drugs as biomedical treatments (Gronfein, 1985). Although controlling symptoms enabled people to leave institutions, many lacked the skills and experience to survive in the community. Furthermore, the use of drugs as treatments was a more subtle form of social control of people with mental illness.

Deinstitutionalisation was based on the principle of normalisation (Nirje, 1985). Normalisation emphasised the importance of people with disabilities being given access to normal lifestyles (Nirje, 1969; Wolfensberger, 1972). It

drew attention to how institutional life deprived people of richness of experience, relationships, and developmental opportunities because all life functions were concentrated in one place (Cocks, 2001).

Psychiatric hospitals were believed to be detrimental to the well-being of patients as they promoted dependency, hopelessness, and helplessness (Goffman, 1961). Deinstitutionalisation consists of three processes: releasing patients from psychiatric hospitals to alternative community facilities, diverting new referrals to alternative facilities, and developing specialised services to care for people with mental illness in community settings (Bachrach, 1976). According to Lamb and Bachrach (2001), the former two processes occurred more rapidly than the third, even though the development of services was deemed most important due to the assumption that it would result in new configurations of services and better quality of life for people with mental illness. Releasing patients and diverting new referrals produced cost savings for institutions, but without community services, many people were left homeless and without care (Eisenberg & Guttmacher, 2010). A parallel development was the establishment of beds and psychiatric services in generic hospitals so that most general hospitals set up mental illness wards.

Deinstitutionalisation has been criticised for failing to provide suitable care in the community before patients were discharged from institutions, which in turn created problems for people with mental illness, their families, and communities (Aviram, 1990; Bachrach, 1976; Becker & Schulberg, 1976; Freedman & Moran, 1984). A number of trends that affected people with mental illness followed in the wake of deinstitutionalisation. Lack of hospital beds led to pressures to discharge patients from hospitals after an inadequate stay and before their illness had been brought under control. This in turn resulted in the same patients returning for repeated hospitalisations in a revolving door cycle (Rieder, 1974). Psychiatric institutions faced increasing pressures to close down and many patients were discharged from these institutions and *transinstitutionalised* into nursing homes and penal institutions (Freedman & Moran, 1984; Swank & Winer, 1976), where they did

not receive appropriate care, or worse still they were left on the streets with no care at all.

Deinstitutionalisation occurred in this fashion in Australia. The Burdekin Report (Human Rights Equal Opportunity Commission, 1993) was critical of Australia's history of neglect and confinement of people with mental illness. It identified that inadequate levels of funding were being directed to community-based mental health and welfare services. In 1992, the First National Mental Health Plan 1993-1997 (Australian Health Ministers, 1992) was developed as part of health care reform in Australia. This historic turning point for mental health policy and service delivery brought together all Australian governments to endorse the principles and plan reform (Mental Health Commission, Government of Western Australia, 2010). After over a decade of continuing deinstitutionalisation and reform, the Mental Health Council of Australia (2005) found through nation-wide consultations that experiences of inadequate mental health and community care still persisted. The report entitled *Not for Service: experiences of injustice and despair in mental health care in Australia* highlighted the deficiencies in community care resource allocation to services for people with mental illness. I have outlined more recent Australian policies and reforms, which form the immediate backdrop of my thesis in Chapters One and Six.

2.2.3 Issues people with mental illness face

Mental illness is associated with higher rates of health risk factors, poorer physical health, and higher rates of deaths from many causes including suicide (Australian Institute of Health and Welfare, 2008). Additionally, poor mental health affects general health and is associated with reduced quality of life and lower productivity (Australian Bureau of Statistics, 2006). According to the 2007 Australian National Survey of Mental Health and Wellbeing, mental illness was linked with indicators of social isolation, including lack of contact

with family and friends, solitary living arrangements, and reduced participation in the labour force (Australian Bureau of Statistics, 2008).

People with mental illness face discrimination in the provision of diagnostic procedures (Lawrence & Coghlan, 2002) and services for physical illness (Fang & Rizzo, 2007). According to Johnstone (2001), "people suffering from mental health problems are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of our society" (p. 201).

Research has shown that meritocratic worldviews that stress personal responsibility are associated with mental illness stigma (Rüsch, Todd, Bodenhausen, & Corrigan, 2010). Goffman (1961) described stigma as a process based on social construction of identity which arises when a personal attribute creates a discreditable gap between our actual social identity (who we think we are) and our virtual social identity (how we are seen by others). He portrayed stigma and shame as a universal human experience, and identified the constantly precarious form of *spoiled identity* as having the effect of cutting stigmatised people off from society and from themselves so that they stand as discredited individuals facing an unaccepting world. This spoiled identity refers to the identity that causes a person to experience stigma (Goffman, 1961). Stigma and spoiled identity as described by Goffman (1961) are associated with Wolfensberger's (1980) identification of social devaluation and wounding Wolfensberger (1980). Stigma represents the endorsement of prejudicial attitudes, negative emotional responses, discriminatory behaviours, and biased social structures towards members of a subgroup in society (Corrigan, 2000). The process of stigma involves the recognition of cues that a person has a mental illness. This cue may be observable such as a symptom, a deficit in social skills, or a difference in physical appearance; or it could be a label or diagnosis (Corrigan, 2004). After being cued into a difference in a person, stereotypes, or knowledge structures that are learned by most members of a social group (Corrigan, 2004; Lenhardt, 2004) are activated. If these stereotypes are negative, prejudice occurs. Prejudice is a result of

cognitive and affective responses to stereotypes. The public behavioural consequence of prejudice is discrimination (Dalky, 2012).

Stigma occurs in the forms of labelling differences, stereotyping or associating human differences with negative attributes, separating "us" from "them" because of social labels, and loss of status by the stigmatised group or person and discrimination (Link & Phelan, 2001). In a meta-analysis, Mak, Poon, Pun, and Cheung (2007) found that stigma had an observable association with a stigmatised groups' mental health. Stigma from mental illness may produce a range of personal responses such as energisation, righteous anger, no observable response, or self-stigma (Corrigan & Watson, 2002). Self-stigma, or internalised stigma (Van Brakel, 2006), is a process where a person loses their previously held or desired identities to adopt and internalise a stigmatised view of themselves (Yanos, Roe, Markus, & Lysaker, 2008). Consequently, the person suffers numerous negative consequences as a result of self-stigma (Corrigan, Watson, & Barr, 2006), such as lower participation in vocational activities (Yanos, Lysaker, & Roe, 2010). The lived experience of stigma is explored further in Chapters Four and Five of this thesis.

2.2.4 Mental health services use of models

People with mental illness often require a broad range of services and support. With the reform of mental health services, Thornicroft and Tansella recommended a *balanced care* approach, with:

> Community-based and hospital-based services that aim to provide treatment and care that are close to home…; are able to respond to disabilities as well as to symptoms; are able to offer treatment and care specific to the diagnosis and needs of each individual; are consistent with international conventions on human rights; are related to the priorities of service users themselves; are coordinated between mental health professions and agencies; and are mobile rather than static (Thornicroft & Tansella, 2004, p. 283).

In Chapter One, I described the mental health and employment services available to people with mental illness in Western Australia. These services are based on a number of different paradigms of care, with psychosocial rehabilitation being the mainstay of emerging personal recovery programs.

The following service provision models have evolved in providing mental health care. As described in the preceding section, historically, mental illness was viewed as moral degeneracy. This view gradually changed over time to accepting mental illness as an illness, and in more recent times, acknowledging mental illness as a disability (Australian Institute of Health and Welfare, 2008).

2.2.4.1 Medical model

A medical view of mental illness became established in the nineteenth century alongside moral management and asylumdom. With the rise of medicine as a scientific discipline, psychiatry became established as a profession. Mental health services have traditionally been based on the medical model of health, which focuses on the physical or mental functional impairment within a person. According to the World Health Organization (2011), this model views disability as a problem within a person, which requires treatment by a medical professional.

The physician using this model is concerned with aetiology, pathogeneses, signs and symptoms, differential diagnosis, treatment, and prognosis. Identifying the disease or syndrome allowed treatment to be determined (Lazare, 1973). Psychotropic drugs were introduced as medical treatment in 1954, and since then have been promoted as a means to redress chemical imbalances in people with mental illness (Sanua, 1996). These drugs are used as antipsychotic, antidepressant, and antianxiety therapeutic agents (Klerman, 1977).

The medical model has been criticised for focussing on impairments and limitations, rather than health, personal strength, and opportunity (Deegan,

1992; Munetz & Frese III, 2001), thus fostering power inequality between treating doctors and their patients (Parsons, 1975). Although the medical model dominated mental health services in the past, it has been challenged by models that have a more holistic focus where service users have more influence over their own care.

2.2.4.2 Biopsychosocial model of mental illness

With the recognition of mental illness as a form of disability, psychiatric rehabilitation procedures developed in order to improve outcomes for people with mental illness. The goal of psychiatric rehabilitation was to enable people with mental illness to perform the physical, emotional, social, and intellectual skills needed to live, learn, and work in the community (Anthony, 1979). In the late 1970s, a new way of understanding mental illness emerged, which integrated the biomedical paradigm with psychological and social factors for identifying the aetiology and treatment of illness (Engel, 1980). This model provided many insights into the cause and course of illness from a multifactorial view. Although revised versions of this model remain as the mainstream ideology of contemporary psychiatry (Ghaemi, 2009), the biopsychosocial model has been criticised as being limited, especially in the area of psychosocial interventions (Richter, 1999). However, this model is still used in contemporary mental health care to ensure a person's connections with family, friends, culture, and community are addressed. The biopsychosocial model was a dominant model in the Australian context, but newer models have developed from it, which have grown in influence.

2.2.4.3 Social model of disability

In the 1980s, medical models were criticised for the way disabled people, including people with mental illness were viewed as lacking and unable to play a full role in society. The social model of disability redirected analysis of

disability from the individual to processes of oppression, discrimination, and exclusion (Oliver, 1996).

> It does not deny the problem of disability but locates it squarely within society. It is not individual limitations, of whatever kind, which are the cause of the problem but society's failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organisation (Oliver, 1996, p. 32).

Although this model serves as a powerful and important reminder of issues of inclusion, it has been criticised as flawed in conceptualising disability as unilaterally socially caused (Terzi, 2004). According to Marks (1999, p. 611), "by excluding personal experience from the analysis of disability, a theoretical vacuum is left, which is filled by those who adopt an individualistic and decontextualized perspective".

More recently, there has been a shift towards modernising the social model of disability, and it has been used as a philosophical basis for shifting the emphasis from the individual to challenging discrimination and securing the human and civil rights of people with disability (Beresford, 2002). This shift aligns this model well with social inclusion of people with mental illness as a rights issue (Sayce, 2001) and recovery in mental illness (Deegan, 1992).

2.2.4.4 Social role valorisation

In response to service systems that only focus on rehabilitation, the concept of normalisation was further developed as social role valorisation by Wolfensberger (1983). Social role valorisation is defined as "the enablement, establishment, enhancement, maintenance and/or defence of valued social roles for people, particularly for those at value risk, by using as much as possible culturally valued means" (Wolfensberger, 1992, p. 32). The theory and principles of social role valorisation have universal applicability to any group of people at risk of social devaluation or exclusion (Williams, 1999).

According to the theory of social role valorisation, people with disabilities, including people with mental illness, are likely to be negatively perceived by society and cast into a negative social role. They are thought of as being of less worth and deserving less respect and consideration than others (Wolfensberger, 1983). This process of social devaluation has consequences, described as *wounds,* such as denial of opportunities, segregation from ordinary community life, imposed poverty, loss of relationships, or increased risk of harm or abuse (Wolfensberger, 1980). Wolfensberger (1992) stressed the importance of sustaining, creating, and maintaining valued social roles for people in society. This could be achieved by providing support for experiences and relationships relevant to a person, and by structuring environments, activities, and other service practices in order to maximise valued perceptions of people, their positive perceptions of themselves, and their competence in achieving and sustaining socially adaptive behaviour (Wolfensberger & Thomas, 1983).

Social role valorisation provides a theoretical basis for why vocation is important for people with mental illness who may be at risk of being devalued and socially marginalised. Engagement in vocational activities allows participation in valued social roles, which in turn enhances quality of life, affords choices, and builds relationships. The connection between social role valorisation and vocation is explored in Chapter Four of this thesis.

2.2.4.5 Psychosocial rehabilitation

People with mental illness want to be included in the activities and experiences of everyday life (Deegan, 1992). In 1996, the World Association for Psychosocial Rehabilitation and the World Health Organization jointly issued a consensus statement that defined psychosocial rehabilitation as a strategy that facilitates the opportunity for individuals with mental illness, to reach their optimal level of functioning in the community, by improving individuals' competencies and introducing environmental changes (1996). Psychosocial

rehabilitation has been defined as "a therapeutic approach that encourages a mentally ill person to develop his or her fullest capacities through learning and environmental supports" (Bachrach, 1996a, p. 28). Embedded within this definition was an increase in recognition of people with mental illness as central in their rehabilitation.

> While the nature of the process and the methods used differ in different settings, psychosocial rehabilitation invariably encourages persons to participate actively with others in the attainment of mental health and social competence goals. In many settings, participants are called members. The process emphasises the wholeness and wellness of the individual and seeks a comprehensive approach to the provision of vocational, residential, social/recreational, educational and personal adjustment services (Cnaan, Blankertz, Messinger, & Gardner, 1988, p. 61).

Mental health service user or *consumer* involvement as members demonstrates an increase in the influence people with mental illness had on their own health care. This *consumerist approach* (Beresford & Croft, 1993) represented a change from viewing people with mental illness as patients within the medical model to customers or consumers of health care services; that is, having valued social roles. However, the term consumer is not without problems, because it implies that people are purchasing services, and may have materialistic connotations to some. Thus, the term can be both empowering and consumerist.

In a review, Barton (1999) identified four service domains of psychosocial rehabilitation: skills training, peer support, vocational services, and consumer-community resource development. The focus of professionally led programs is not on curing a person's disability, but on learning how to manage it and living with the limitations it imposes (Corrigan, 2003). These programs aim to assist consumers to improve their social functioning, obtain successful employment, achieve independent living, and engage in healthy social relationships. Some

psychosocial treatments have a growing evidence-base, including social skills training and cognitive-behavioural therapy (Kern, Glynn, Horan, & Marder, 2009). Psychosocial rehabilitation through diverse models and health care settings is the commonly accepted form of health care provision for people with mental illness in Australia. These psychosocial rehabilitation models and health care settings were introduced in Chapter One, where I outlined the contemporary context of the research in Western Australia. They also form the backdrop for the stories of participants in the study who have a mental illness and who are required to navigate a complex array of services.

2.3 Recovery

Although there is an ever increasing evidence base for recovery practices, lack of clarity of recovery principles and practices still exists in service provision in Western Australia. This section details a shift from clinical recovery to personal recovery, discusses what personal recovery means for people with mental illness, and outlines the change in orientation in contemporary mental health services in Western Australia towards recovery.

2.3.1 Paradigm shifts towards recovery

The ideologies of recovery are varied and complex. Recovery has domains of clinical, functional, social, and personal, which have different underpinning philosophies. Clinical recovery from mental illness is focussed upon the amelioration of symptoms, which has been the goal in treating mental illness using the medical model. Liberman and Kopelowicz (2002) defined recovery as symptom remission, full- or part-time involvement in work or education, not being financially dependent on disability support, independent living without supervision by family or informal carers, and having friends with whom activities can be shared – sustained for a period of two years. This definition has clinical, functional, and social elements.

Since the mid 1980s, there has been a change in perspective from clinical recovery to considering recovery from the consumers' point of view. Personal recovery has gradually superseded clinical recovery and is now more generally accepted by clinicians and consumers. A number of longitudinal studies debunked the commonly held belief that the best achievable result for people with severe mental illness was stability. These studies found that people with severe mental illness progressed beyond a state of stability, with outcomes of full or partial recovery in the majority of participants either with or without the assistance of mental health services (Ciompi, 1980; DeSisto, Harding, McCormick, Ashikaga, & Brooks, 1995; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Harding & Zahniser, 1994; Huber, Gross, Schüttler, & Linz, 1980). Harding et al. (1987) found that people with mental illness were in recovery in a sense that they had a social life and held a paid job or volunteered. Subsequent to these findings, the concept of recovery began to obtain legitimacy (Sullivan, 1997), and has grown from a consumer-led movement to being extensively researched and used in the development of policy and services.

2.3.2 Defining personal recovery

Defining personal recovery has been difficult because it is a personal experience that is complex and varies between people. The most widely accepted definition of recovery is:

> A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993, p. 159).

There are overarching themes that have emerged from research and consensus literature that define recovery. Personal recovery is described as the process of

transcending symptoms, psychiatric disabilities, and social handicaps (Anthony, 1993, 2000). Ramon, Healy, and Renouf (2007) described recovery from mental illness as featuring strength, self-agency, hope, interdependency, giving, and systematic effort which entails risk-taking. Davidson and Roe (2007) provided additional clarification in describing recovery *from* and recovery *in* mental illness, in that although some people do recover *from* mental illness symptoms, many also live *in* recovery and find meaning and purpose in life even with ongoing symptoms. Essentially, recovery involves living as well as possible, and involves hope, agency, and opportunity for people with mental illness (South London and Maudsley NHS Foundation Trust, 2010). According to Deegan:

> For many of us who are disabled, recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfect linear process. At times, our course is erratic and we falter, slide back, re-group and start again… We cannot force recovery to happen in our rehabilitation programs. Essential aspects of the recovery process are a matter of grace and, therefore, cannot be willed (Deegan, 1988, p. 15).

The same author also pointed out that most people with disabilities shared the same fundamental needs and aspirations:

> The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution (Deegan, 1988, p. 11).

In Australia, people with mental illness have welcomed the focus on recovery of policy and services. Even though notions of recovery have been widely discussed and many consumers of mental health services are sharing their recovery stories (Ellis, 2003; Rinaudo & Ennals, 2012; Schiff, 2004; Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003), there still remains a

difficulty in creating a single definition of recovery. Many definitions mix clinical and personal aspects of recovery, and this is reflected in how it is understood and practiced by service providers. Although the theoretical understandings of recovery in mental illness are developing, tensions exist for services that have to operationalise these definitions, as well as report on outcomes and key performance indicators associated with clinical outcomes.

2.3.3 Recovery-oriented services

The evidence base for recovery practice and outcomes is growing. In 2003, (Andresen, Oades, & Caputi), developed four key processes of recovery, namely finding hope, re-establishment of identity, finding meaning in life, and taking responsibility for recovery. More recently, Leamy, Bird, Le Boutillier, Williams, and Slade (2011) published a systematic review that identified the characteristics of the recovery journey, processes, and stages. From this, they reported that recovery processes comprised connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. Tew et al. (2012) further investigated the three more social aspects of recovery processes in a review. They identified key social factors, such as engaging with family and communities, which promoted empowerment and negotiation of positive social identities, supportive personal relationships, and social inclusion. Critical components of recovery are social inclusion and citizenship (Boutillier & Croucher, 2010).

The vision of recovery enables people with mental illness to build satisfying, meaningful lives by focussing on personal strengths and capacities (Thornton & Lucas, 2011). Hope and optimism was reviewed by Schrank, Bird, Rudnick, and Slade (2012), who reported that the interventions to improve hope were collaborative strategies for illness management, fostering relationships, peer support, helping clients assume control and to formulate and pursue realistic goals, and specific interventions to support multiple positive factors such as self-esteem, self-efficacy, spirituality, and wellbeing.

In Australia, a shift toward recovery approaches has occurred at a policy level with health care reform. The National Standards for Mental Health Services stated that mental health services must uphold the right of consumers to be involved in all aspects of their treatment, care, and recovery planning, and acknowledge consumers as partners in managing their recovery (Commonwealth of Australia, 2010). There has been an ongoing emphasis on community-based recovery in Australia, with the last four National Mental Health Plans (Australian Health Ministers, 1992, 1998, 2003, 2009) having a major focus on developing the community-based service network according to consumer needs. However, despite these ongoing reforms, reports by the Mental Health Council of Australia (2005) and the Senate Select Committee on Mental Health (2006) described clearly a mental health system that was in crisis. The Mental Health Council of Australia criticised the success of reform and recommended that:

> Community Supported Recovery Services must have a true recovery focus based on a close interaction between clinical and non-clinical services and a range of psychosocial support services. Community services and consumer operated services can often provide effective peer support and assistance (Mental Health Council of Australia, 2005, p. 13).

Following this, the Fourth National Mental Health Plan specified social inclusion and recovery as its first priority area (Australian Health Ministers, 2009).

There is some support in policy and a growing evidence base for recovery-oriented services. However, there are varying understandings of what recovery is for service providers. This is an issue that I explore in Chapters Five and Six.

2.4 Theories of Vocation

The word *vocation* signifies a range of connotations and assumptions about work and its relation to an individual's life worth, choice, and validity. In much of the literature the words vocation, work, occupation, employment, and career are used synonymously, with the concept of vocation seemingly having lost its historical connotation of a calling to service in a religious or humanitarian context (Bogart, 1994). This section explores the overarching notion of vocation and its subsidiary concepts of work and employment as they are focal points in this thesis. There are many terms and metaphors in the literature surrounding vocation that are common with recovery, for example choice, self-identity, and pathways. However, a tension may arise in relation to the linearity of terms such as pathways, and the literature on recovery, which builds in change and the capacity for some unpredictability. Nevertheless, vocation is also changing in a contemporary landscape where people generally are likely to change careers at least once in their lives. Theories of vocation are central to understanding participants' vocational experiences as described in chapter four, descriptions of vocational recovery in chapter five, and exploring how services in Western Australia assist people with mental illness in their vocational recovery journeys as detailed in Chapter Six.

2.4.1 Theological and existential underpinnings of vocation

A derivative of the Latin terms *vocare* or *vocātiō*, meaning to call, vocation was a term first used in the Middle Ages to describe a call away from an existence of productive activity in order to dedicate one's life to prayer and contemplation (Beder, 2000). "A 'vocation' or 'calling' originally referred to the work of monks, nuns and priests who served God by removing themselves from daily life and serving the church" (Beder, 2000, p. 14). This school of thought propagated a religious devaluation of earthly occupations (Hardy, 1990). Martin Luther, John Calvin, and other reformers of the sixteenth century disputed this prevailing view and argued that a divine calling could be

followed no matter what one's occupation. As such, non-religious work was seen as a blessing and something to be enjoyed (Beder, 2000).

According to Bloland and Walker (1981), vocation can be conceptualised as "a means for fulfilment and a way of existing in the world" (p.199). "Vocation as a quest for authentic existence is supported by the existentialist tradition of Heidegger (1949, 1962)" (In Homan, 1986). Existentialism is associated with deconstructing one's external influences, discovering the absurdity in human values, eliminating superficial and frivolous impacts on life, finding true meaning and purpose in life, and pursuing a path of authentic thought and action. According to (Homan, 1986), vocation is defined as the "matrix of meaning that one attributes both to one's career and to oneself" (p. 15). This sense of purpose and calling beyond one's own agency is a meaningful notion for many people (Weiss, Skelley, Hall, & Haughey, 2001).

2.4.2 Sociocultural Theoretical Perspectives

The following section describes the theories that underpin work and careers, and how we are shaped by engagement in these activities. Morse and Weiss (1955) described the meaning of work as not just a function by which one earns a living, but a way of being connected to society and having purpose in life. In a review of literature on employment and mental health, Marrone and Golowka (1999) asserted that working was not just a right, but a responsibility as part of a social contract for citizens. The authors stated that unemployment was far more detrimental to one's mental health than the stresses of employment, and listed benefits associated with work such as meeting people, expanding social networks, distraction from disability, and creating interest in daily life.

Career development theories have emphasised the clarification of one's vocational identity, a clear and stable picture of one's goals, interests and talents, in order to develop future orientation (Super, 1980). A fundamental task for individuals is the construction of a guiding vocational narrative that

states their work in a purposeful vision. Vocational identities are embedded in narratives or subjective schemas that individuals form around seeing themselves as workers and describing this vision (Bujold, 2004). Vocational education should facilitate the capacity to detect meaningful challenges, pose responsible visions, and engage in living a coherent story of vocation (Rehm, 1999).

Work choices, commitment and experimentation build vocational identities. The Social Cognitive Career Theory conceptualised career-related interest, choice, and performance, as well as the interplay among social cognitive variables in guiding career development (Lent, Brown, & Hackett, 1994). According to Social Cognitive Theory (Bandura, 1989), human motivation and actions are regulated comprehensively by forethought. The main influence on behaviour is perceived self-efficacy – a person's belief in their capabilities to perform a specific action required to attain a desired outcome. Self-efficacy affects goals, aspirations, motivation levels, resilience, and outcome expectancies, all of which may predict behaviour (Bandura, 1989, 2001). According to the Social Cognitive Career Theory, vocational self-efficacy is acquired through prior vocational performance accomplishments, vicarious learning through modelling others' occupational behaviour, receiving encouraging verbal messages from significant others, and lowering anxiety in order to improve one's functioning in a supportive and low-stress environment (Lent et al., 1994). Vocational self-efficacy may be a mediating variable in implementing vocational interests and may affect an individual's vocational choices and behaviour.

Warnath (1975) cautioned that because most people work for organisations whose survival is dependent upon operating efficiently and generating profit, the connection between work and fulfilment through expression of one's individuality has been severed. According to Green (1968):

> We have learned to view work as the way in which a man [sic] defines for himself who he is and what he shall do with his life. The difficulty is,

> however, that today men [sic] must do this increasingly in society that lists among its primary purposes the efficient production of goods and services rather than celebration of human dignity. They have to undertake their self-definition in an environment that has purposes of its own and for that reason does not have room for individuals to express their own purposes (p. 35).

This view may be true for some people; however, engagement in meaningful and/or purposeful work, namely vocation, may be part of a person's authentic expression of themselves. In chapter four, participants' understandings of vocation and how it relates to their lives are explored and discussed.

2.4.3 Theoretical frameworks underpinning the thesis findings

In order to answer the research questions described in Chapter One, occupational justice and ecological theories were used as frameworks to describe how people with mental illness establish and achieve their vocational goals within the context of recovery. Theoretical understandings of occupational justice and ecological systems form the basis from which this thesis is written, apportioning associations between vocation, vocational pathways, and vocational recovery in mental illness. These theories are presented in the following sections.

2.4.3.1 Occupational justice

The process of shaping the course of life by daily occupation has been referred to as "doing, being, and becoming" (Wilcock, 1998, p. 341). Kielhofner (1995, p. 3) defined occupation as "doing culturally meaningful work, play or daily living tasks in the stream of time and in the context of one's physical and social world". There is considerable overlap in definitions of vocation described in this chapter and "culturally meaningful work" (Kielhofner, 1995, p. 3), which is part of occupation. As such, the theoretical framework with which one understands participants' vocational journeys in Chapter Four is enriched by an occupational perspective. Engaging in occupation fosters autonomy,

meaning in life and fulfils desired or assigned roles. In addition, it is through occupation that *flow* occurs. Flow is the state in which a person performing an activity is fully immersed in the process of the activity. It is characterized by complete absorption in what one does (Csikszentmihalyi, 1997). According to Csikszentmihalyi and Csikszentmihalyi (1992), activities producing flow allow growth and development as human beings.

People engage in occupations, or culturally and personally meaningful activities during the course of their daily lives (Law, 2002). In a novel, Harold Bell Wright identified occupation as one of the "thirteen truly great things of life", and in a chapter on occupation, he wrote:

> In all the world there is no danger so menacing as the danger of idleness: there is no privation so cruel, no suffering so pitiful, as the need of Occupation: there is no demand so imperative, no necessity so dreadful, as the want of something to do. Occupation is the very life of life. As nature abhors a vacuum so life abhors idleness. To be is to be occupied (Wright, 1912, p. 45).

Humans are occupational beings whose existence depends on the enablement of diverse opportunities and resources for participation in culturally-defined and health-building occupations. Occupational science proposes that occupation is fundamental to human life (Yerxa, 2000) and that it is essential for health (Wilcock, 1998). An occupationally just society enables all people to have the resources to engage in occupations that they need and want to do regardless of disability, socio-cultural position, geographic location, age or gender (Townsend et al., 2003; Townsend & Whiteford, 2005).

The occupational justice framework focuses on participation in occupations as a basis of health and well-being. It addresses moral, ethical, and civic concerns of health, empowerment, and quality of life (Townsend & Whiteford, 2005). When a person with mental illness is deprived of participating in meaningful and purposeful occupations, injustice occurs. According to Stadnyk, Townsend, and Wilcock (2010), the four forms of occupational injustice are:

occupational imbalance, marginalisation (Townsend & Whiteford, 2005), deprivation, and alienation. Occupational imbalance is term that identifies populations that do not share in the labour and benefits of economic production (Townsend & Wilcock, 2004). Occupational marginalization refers to the human need to make everyday choices and decisions as we participate in occupations. According to Nagle, Cook, and Polatajko (2002), occupational marginalization may occur when people with disabilities (including people with mental illness) are excluded from employment opportunities and have few expectations that employment is even possible. Occupational deprivation (Whiteford, 2000), by having limited opportunities and lack of personal choice to participate in occupations, occurs with community barriers that exclude people (Wilcock, 2006). Occupational alienation describes meaningless and purposeless everyday life experiences (Townsend & Whiteford, 2005). It is believed to occur with subjective experiences of "isolation, powerlessness, frustration, loss of control and estrangement from society or self as a result of engagement in occupation that does not satisfy inner needs" (Wilcock, 2006, p. 343). The concept of occupational justice provides a framework that links stigma (Goffman, 1961) and wounding (Wolfensberger, 1972) people with mental illness experience to personal recovery principles and practices, as well as vocation as part of occupation.

2.4.3.2 Ecological theory

One of the research questions in this thesis explores how vocation fits into current understandings of recovery and how vocational recovery in mental illness may be described. In order to answer this question, an ecological framework was used to provide a holistic way of categorising elements of this complex description. The Process-Person-Context-Time Model (Bronfenbrenner, 1977, 2005, 2009) has been used as a framework to understand how people interact with their environments. The theory has two central propositions that describe process:

> [H]uman development takes place through processes of progressively more complex reciprocal interaction between an active, evolving

> biopsychological human organism, and the persons, objects, and symbols in its immediate external environment. To be effective, the interaction must occur on a fairly regular basis over extended periods of *time.* Such enduring forms of interaction in the immediate environment are referred to as *proximal processes* (Bronfenbrenner & Morris, 1998, p. 996).
>
> The form, power, content, and direction of the proximal processes effecting the development vary systematically as a joint function of the characteristics of the *developing person*; of the *environment* – both immediate and more remote – in which the processes are taking place; the nature of the *developmental outcomes* under consideration; and the social continuities and changes occurring over *time* through the life course and the historical period during which the person has lived (Bronfenbrenner & Morris, 1998, p. 996).

The ecological theory places the person at the centre. Bronfenbrenner described personal characteristics, namely demand, resource, and force characteristics. Demand characteristics include age, gender, ethnicity, and physical appearance, which influence initial interactions due to immediate expectations based on these characteristics (Bronfenbrenner, 1995). Resource characteristics relate to mental, emotional, social, and material resources that may not be immediately apparent, but serve to support the individual in different contexts. Force characteristics include differences in temperament, motivation, and persistence (Bronfenbrenner, 1995; Bronfenbrenner & Morris, 1998).

The context or environment comprises four interrelated systems: microsystems (where the person spends the most time engaging in activities and interactions), the mesosystem (where interrelations between various microsystems occur), the exosystem (is not a context where the person is situated, but it has an indirect influence on them), and the macrosystem (which encompasses any social or cultural group) (Bronfenbrenner, 1994). The

final element of the ecological model is time, which is fitting for a human development theory.

The occupational justice framework and the ecological model are useful in describing consumers' personal characteristics, participation in meaningful activity, engagement in vocational pursuits, and the facilitators and barriers they encounter over time. This provides a holistic understanding of factors that may affect their vocational journeys. These two models have strong theoretical connections with the principles of the recovery model, where person-centredness, social inclusion, and citizenship are emphasised (Barker, 2001; Boutillier & Croucher, 2010). The occupational justice framework is used in Chapter Four and the ecological model forms the basis of the Framework for Facilitating Vocational Recovery in Mental Illness in Chapter Five.

2.5 Vocation for People with Mental Illness

Vocation for people with mental illness is poorly understood. Although vocation better incorporates the broad concept of personal recovery, much of the literature loosely related to this topic refers to employment and work. In this thesis, vocation is defined as that which is meaningful to the person. Employment and work are subsets of vocation and may not convey the whole representation of vocation. This section presents the literature on employment and work for people with mental illness as a way of introducing the topic and locating people with mental illness within the broader issue of a labour force.

2.5.1 How employment affects mental health

It is generally accepted that with unemployment comes experiences that undermine a person's self-esteem and sense of well-being. Employment provides income as well as an opportunity for social engagement and improved self-esteem. It may be a means of recovery and a source of wellness for people with mental illness (van Niekerk, 2009).

Unemployment has been shown to have a number of negative outcomes for people with mental illness including loss of purpose, roles, status, and sense of identity (Waghorn & Lloyd, 2005). Alternatively, employment has been shown to have significant health benefits for people with mental illness including improved quality of life, reduced psychiatric symptoms, improved general functioning and reduced rates of relapses (Grove, 2001; Noble, 1998). Employment promotes social inclusion for people with mental illness encouraging meaningful participation in the community (Office of Mental Health, 2004) and a pathway to independence from welfare and poverty. Despite the benefits of participating in the workforce, three out of four persons with mental illness in Australia remain unemployed (Waghorn & Lloyd, 2005). It is not surprising that exclusion from employment has been highlighted as a major difficulty people with mental illness have to face (The Wesley Mission, 2007). The National Mental Health and Disability Employment Strategy (Commonwealth of Australia, 2009) recognized that having a job was an essential part of social inclusion and specified several strategies to ensure Australians with disability and mental illness had improved opportunities to search, find and maintain employment.

2.5.2 Employment of people with mental illness

As mentioned in section one of this chapter, for people with mental illness, the effects of stigma can have negative consequences. Having reduced employment opportunities is one such consequence. Green, Hayes, Dickingson, Whittaker, and Gilheany (2003) found that employers assume that people with mental illness may be more likely to be absent, dangerous, or unpredictable. A study found that 50% of employers would *never* or *rarely* employ a person who they knew to have a psychiatric disorder (Manning & White, 1995). In a review, Brohan et al. (2012) found that disclosure of a mental illness places job applicants at a disadvantage in securing employment as compared to applicants with physical or no disability.

The medical model has been criticised as not emphasising employment (Organisation for Economic Co-operation and Development, 2012). Service providers may contribute to barriers people with mental illness face in terms of obtaining work by overestimating possible negative consequences of work for people with mental illness (Roets, Kristiansen, Van Hove, & Vanderplasschen, 2007) and underestimating the capacities and skills of consumers whilst overrating the risk to employers (Boardman et al., 2003). This overprotection of people with mental illness leads to exclusion from work and is a form of oppression and stigma in itself (Marrone & Golowka, 1999).

Link (1987) found that people labelled *mentally ill* were more likely to be underemployed and earn less than people with the same psychiatric difficulties without the label. Just labelling alone can affect employment opportunities, discounting a person's knowledge, abilities, education, or qualifications for a particular job. The stigma of being labelled mentally ill has disabling consequences in the form of social exclusion (Thornicroft, 2008).

Research has shown that work has personal meaning for people with mental illness and work promotes recovery (Dunn, Wewiorski, & Rogers, 2008). For people with psychosis, participating in work affords greater social contact and independence (Bond, 2004), as well as improved self-esteem (Lehman, 1995). People with serious mental illness also benefit from workplace social networks through experiences of low criticism and stress from workplace relationships and high amounts of satisfaction with these relationships (Rollins, 2011).

Recently, there have been a number of reviews of return to work and vocational rehabilitation research for people with mental illness. Fossey and Harvey (2010) performed a meta-synthesis of vocational research in order to explore mental health consumers' experiences and viewpoints regarding attaining and keeping employment. They found that gaining employment held specific and varied meanings, benefits, and drawbacks to weigh up. A second finding was that a variety of self-management strategies for maintaining employment and mental health were important in sustaining employment.

Diverse supports within the workplace, connections with peers and family, and employment specialist and mental health services support were helpful in facilitating job-seeking, sustaining jobs, and managing work stress (Fossey & Harvey, 2010). A final finding was that systematic issues added to the employment barriers that people with mental illness faced. Andersen, Nielsen, and Brinkmann (2012) investigated the experience of people with common mental disorders returning to work, as well as the opportunities and obstacles they faced in a qualitative meta-synthesis. They found that employees with common mental disorders experienced difficulties in deciding when they were ready to return to work and problems applying return to work strategies whilst at work. Further to this, facilitators and barriers to successful return to work included individual factors, social support, accommodating workplaces, and negotiating social and rehabilitation systems (Andersen et al., 2012). The experiences reported by these two reviews strongly represent the viewpoints of people with mental illness. Although there is a body of research about the experience of job-seeking and employment for people with mental illness, there is a paucity in research with regards to vocation as it has been defined in the previous section. In Chapter Four, I describe people with mental illness' understandings and experiences of vocation, along with the facilitators and barriers they face in attaining their vocational aspirations.

2.5.3 Vocational Recovery

In the last eleven years, researchers have begun to use the term *vocational recovery* to describe employment of people with mental illness. Vocational recovery has been defined as: "the outcome of preserving, regaining, or acquiring competitive employment after being affected by serious mental illness" (Russinova, Wewiorski, Lyass, Rogers, & Massaro, 2002, p. 303). This definition has specific dimensions embedded in it, namely the recovery thresholds of six months of competitive employment per year and ten hours of work per week (Russinova et al., 2002). The notion of generalised thresholds in this study may have been conceptualised in line with Social Security

Administration requirements in the United States of America. Although these linear, quantified dimensions legitimately define vocational recovery, they exist within a bureaucratic framework. More recently, Dunn, Wewiorski, and Rogers (2010) defined vocational recovery in a similar manner, as the process through which people with mental illness regain their worker role and reintegrate into the workforce. Two out of the three authors of this research were also on the Russinova et al. (2002) paper, and they were reporting on a similar American experience.

In Australia, the term vocational recovery has also been used by researchers to describe employment outcomes. Waghorn, Chant, and Whiteford (2002) investigated four aspects of vocational recovery, namely: current employment, durable employment, self-reported work performance, and absenteeism. Baksheev, Allott, Jackson, McGorry, and Killackey (2012) labelled describing the attainment of competitive employment or attendance in an education course during a six-month period as vocational recovery. These authors neither defined vocational recovery, nor situated the notion of vocation within the well-established personal recovery framework.

As discussed in previous sections of this chapter, vocation is meaningful for people, including people with mental illness. Personal recovery in mental illness is described using metaphors that are similar to those used in vocational literature. Both vocational and recovery processes use terms that reflect journeys, personal stories and narratives, and living constructive lives (Buchanan-Barker & Barker, 2008; Inkson, 2004; Jacobson & Greenley, 2001). A recent review by Leamy et al. (2011) described recovery processes comprising connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. Recovery is accepted as a non-linear and personal journey (Leamy et al., 2011). These nuances of recovery are sometimes lost in its use in the literature. Perkins and Repper (2004) highlighted the risk that recovery could "become the latest catch phrase used merely to reframe traditional activities" (p. 335). In the same way that *medical recovery* is only a potential part of *life recovery* for people with mental illness (Collier, 2010); employment

or work is only part of the broad, personally-defined notion of vocation. By using the term *vocation* interchangeably with work and employment, and pairing it with the appropriated term *recovery*, the studies mentioned in the preceding two paragraphs have reduced these two rich and meaningful concepts to linear, arbitrary outcomes. In Chapter Five, I provide a definition of vocational recovery in mental illness that captures the richness and nuances of both vocation and recovery.

2.5.4 Moving towards an evidence-based model of vocational rehabilitation

As introduced in Chapter One, the term *vocational rehabilitation* is used to describe the process of assisting people to return to work activities or participate in the workforce. Although the term vocational is used, the services providing this assistance only focus on employment.

Traditional vocational rehabilitation services rely on employment readiness, which in turn is based on rehabilitation readiness, a key concept in psychiatric rehabilitation since the 1980s. Readiness refers to a person's interest in and willingness to engage in the process of rehabilitation in order to accomplish a goal (Farkas, Soydan, & Gagne, 2000). If employment is the goal, rehabilitation focuses on the requisite skills in preparation for job seeking. In practice, this may mean long periods of preparatory activities that focus on specific skills prior to vocational rehabilitation. Employment readiness has been found to be relevant in vocational rehabilitation, as well as supported employment (Roberts & Pratt, 2007, 2010).

The Supported Employment model has steadily increased in prominence as an evidence-based mental health practice and this approach has been widely adopted by vocational service providers internationally. The main principles of supported employment are that placement in competitive employment should occur as quickly as possible in an integrated work setting, followed by ongoing job support and training (Bond, 2004). A ten-year study of a supported

employment program for people with mental illness reported long term effectiveness with client-reported benefits such as improvements in self-esteem, hope, relationships and control of substance abuse (Salyers, Becker, Drake, Torrey, & Wyzik, 2004).

Individual Placement and Support is an evidence-based approach to supported employment for people with mental illness that was developed by Becker and Drake in 1993. Results from several randomised controlled trials and systematic reviews found that the IPS was effective in assisting people with mental illness obtain competitive employment and enhancing vocational outcomes in the USA (Bond, 2004; Bond et al., 2008; Burns et al., 2007; Crowther et al., 2001; Dixon et al., 2010; Twamley et al., 2008), in Canada (Latimer et al., 2006), in Europe (Burns et al., 2007), in the UK (Heffernan & Pilkington, 2011), and in Australia (Killackey & Waghorn, 2008). These various studies provide a backdrop for the kinds of services which have populated the Australian mental health landscape throughout the early 2000s until the present day. I will return to discuss different aspects of the studies, particularly in Chapters Five and Six.

Individual Placement and Support involves the provision of a supported employment intervention by an individual service provider working directly with a consumer. According to Bond (1998), the core principles of IPS include competitive employment as a goal, rapid job search, integration of rehabilitation and mental health services, attention to consumer preferences, continuous and comprehensive assessment and time-unlimited support. The principle of rapid job search has been challenged as a risk for people with mental illness whose needs may require more time to address than the approach provides for (Roberts & Pratt, 2007). About two-thirds of IPS participants are successful in attaining competitive employment, typically working 20 hours or more a week (Bond, Drake, & Becker, 2012; McHugo, Drake, Xie, & Bond, 2012). Although IPS is effective in achieving high employment success rates, job tenure has been found to be brief (Bond et al., 2008; Bond, Drake, Mueser, & Becker, 1997; Mueser et al., 2005). Recently,

Bond and Kukla (2011) measured durations of job tenure in high fidelity IPS programs in America, ensuring adequate sample sizes and follow-up periods. They found that job tenure was twice as long as previously reported, and that about 40% of consumers became steady workers over two years.

Consumers served by models that integrated psychiatric and vocational service delivery were more than twice as likely to be competitively employed as those who accessed services with low integration (Cook et al., 2005). Assimilating these two types of services is in keeping with a move from the medical model towards psychosocial and recovery approaches. In order to improve vocational outcomes from IPS, psychosocial interventions have been used to augment programs (Gold et al., 2006; McGurk, Mueser, Feldman, Wolfe, & Pascaris, 2007; Mueser et al., 2005; Tsang, Chan, Wong, & Liberman, 2009).

In Australia, Morris and Lloyd (2004) found that the low level of integration between mental health services and vocational services was a barrier to successful vocational rehabilitation. This fragmentation of services due to different funding sources was described by (Drake & Bond, 2011) as a barrier to offering supported employment. Unfortunately, the contemporary Australian system features this fragmentation of mental health and vocational services, as well as their funding sources.

A key recommendation of the Australian Inquiry into Mental Health and Workforce Participation was that the "Commonwealth Government explore ways, in partnership with the states and territories through COAG, to support Individual Support and Placement (ISP) [*sic*] and other service models that integrate employment services and clinical health services" (House of Representatives Standing Committee on Education and Employment, 2012, p. 238). However, the commitment of the Government to this seems questionable, because the only model that is evidence-based is the IPS model, and there are no other service models that have been researched as extensively. Furthermore, DES providers who had piloted IPS programs and were specialised mental health services did not get funded in the last round of

tenders in 2012. Larger national providers were preferred instead. Besides this, the IPS model was not even named correctly in the document. This occurrence is discussed further in Chapter Six.

2.6 Conclusion

From the literature reviewed in this chapter, it is clear that people with mental illness are vulnerable and experience social devaluation and stigmatisation, and have done so throughout history. There are competing paradigms of care in Western Australia, with psychosocial rehabilitation being the mainstay to emerging personal recovery programs. There is an ever increasing evidence base for recovery practices; however lack of clarity of recovery principles and practices still exists in service provision and policy. These ideas will become clearer throughout the thesis as I discuss recovery principles and practices in Chapters Four, Five, and Six.

Theories of vocation underpin its description as meaningful education, work, employment, or volunteering that provides fulfilment and expression of a person's authentic self. However, vocation for people with mental illness is poorly understood. In Australia, vocational services for people with mental illness focus solely on training and employment, yet as I have argued these elements, as important as they are, are only a subset of vocation. People with mental illness benefit from employment as part of their recovery journeys; however, there remains a disconnect between mental health and employment services. This is largely due to Government policy limitations, which prevent DES providers from developing fidelity with an evidence-based model of employment for people with mental illness.

Chapter Four describes people with mental illness' understanding of vocation and their engagement in vocational activities, as well as the facilitators and barriers they encounter in Western Australia. This forms a backdrop to an exploration of the principles and practices associated with vocational recovery, which is presented in Chapter Five. Chapter Six describes vocational recovery

in the Western Australian context, and contains an analysis of policy confusion that exists as a barrier to vocational recovery in mental illness. In the chapter that follows, I describe the overarching methodological approach of the study.

Chapter 3: Methodological Design of the Study

3.1 Introduction

This research explores the issues of vocational recovery for people with mental illness from two perspectives. First, it seeks to understand and document the various barriers and enablers to vocational recovery from the viewpoint of those who experience mental illness. Second, it examines the manner in which service providers and policy makers define vocational recovery and respond to the needs of people with mental illness as they aspire to meaningful vocation while moving through their vocational journey. The research used a diverse range of qualitative methods in order to describe an emerging and under-developed area. While the research was exploratory, the methodological theories and techniques were also chosen to be both inclusive and iterative in order to build the foundations of an authentic theoretical framework of vocational recovery.

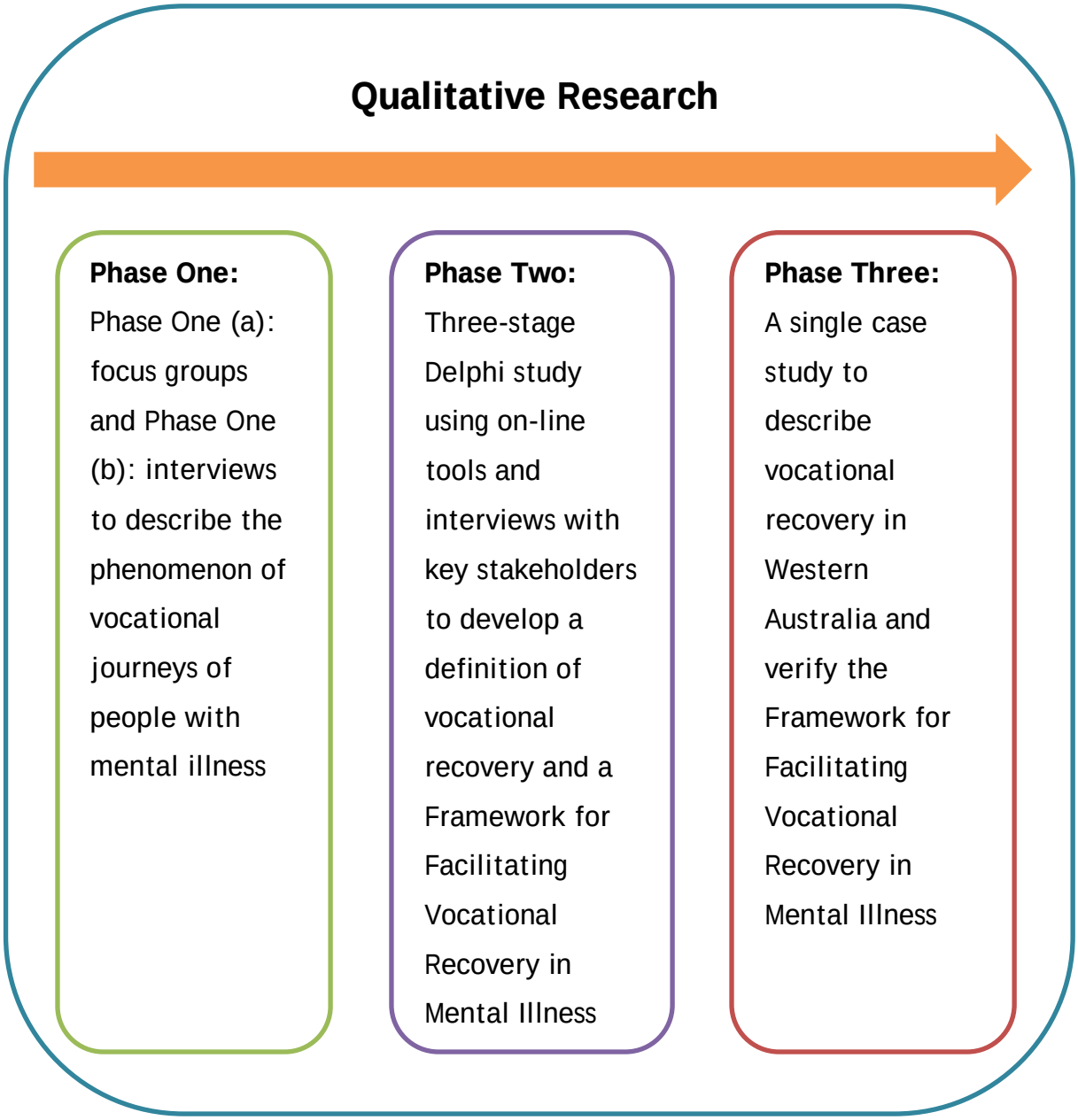
This chapter describes the overarching approach to this qualitative study on a vulnerable population, provides an outline of the research phases, and details the theory base of the methods used in each of the three phases of the study. It presents methodological and contextual issues underpinning the study, whereas the methods for each phase of the study are described in detail at the beginning of Chapters Four, Five, and Six.

3.2 Overview of research

This research project comprised three phases. Phase One used an inclusive approach to describe the phenomenon of vocation for people with mental illness. Phase One involved two stages. Phase One (a) involved a focus group, which had two purposes: firstly, providing preliminary answers to the research questions; and secondly, using an inclusive approach to designing an interview guide for the second stage of this phase. Phase One (b) involved in-depth interviewing and data analysis using an inclusive approach where people with

mental illness were part of the research team. In Phase Two, key stakeholders were Delphi study panellists and they informed a descriptive framework of vocational recovery. Key stakeholders included consumers, service providers, academics, policy makers, advocates, and family members. Phase Three was a case study of vocational recovery in Western Australia, where key service providers and documents informed the research. An overview of the research process is shown in the figure below:

Figure 3.1: Overview of research process



3.3 Qualitative Research

Qualitative research aims to understand and explain participant meaning (Morrow & Smith, 2000). A qualitative approach was chosen as the most appropriate means of exploring personal experiences and meanings regarding vocational aspirations, choices, and journeys of people with mental illness. Equally so, it was the approach of choice for developing a framework of consensus around vocational recovery from the perspective of consumers, service providers, and policy makers, as it allowed exploration and description of the phenomenon of vocational recovery.

> Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials – case study, personal experience, introspective, life story, interview, observational, historical, interactional, and visual texts – that describe routine and problematic moments and meanings in individuals' lives (Denzin & Lincoln, 2011, p. 2).

I employed an interpretive, multimethod approach using group and individual interviews, open-ended text-based surveys, and a case study in this three phase study to develop a deeper understanding of the research questions inductively, from within consumers' and key stakeholders' real life experiences of vocation and recovery. The study is classified as a multimethod design because it is based on multiple qualitative methods and data sets (Morse, 2003). According to Morse (1991), the *theoretical drive* is the primary way in which the researcher is thinking overall about a research topic. The theoretical drive in this research was inductive, where I worked to discover the meaning of vocational recovery in mental illness. Three qualitative methods were used sequentially in this study, commencing with a phenomenological study in Phase One to explore the lived experiences of people with mental illness of

vocation. I then conducted a Delphi study, which was the dominant or core method used to understand the meaning of vocational recovery in mental illness from key stakeholders perspectives. The final phase supplemented the second phase using a case study to explore vocational recovery in practice in Perth, Western Australia. Using the notations suggested by Morse (2003), *qual → QUAL → qual* depicts the specific multimethod design used, that is three qualitative methods used sequentially, where the second method is dominant and supplemented by the first and last methods.

According to Evered and Louis (1981, p. 385), qualitative research may be viewed as "inquiry from the inside", where the researcher aims for a holistic picture from historically unique situations, noting features that are important for meaning. The researcher uses an inductive mode, allowing the data to convey meaning.

Mason (2002) provided guidelines for the qualitative researcher, and stated that the research should be conducted systematically and rigorously, and should be strategic, flexible, and contextual. As the researcher is accountable for its quality and claims, they should engage in critical scrutiny or active reflexivity, and produce convincing arguments. This was important in guiding this exploratory and developmental study, whilst ensuring its trustworthiness.

With regards to presentation of findings, there are two main approaches used in qualitative research (Burnard, 2004). The first approach involves reporting key findings in a *Results* section under main themes or categories and using appropriate verbatim quotations to illustrate the themes. A separate *Discussion* section would then follow, where results are critically discussed and compared with appropriate research within the existing body of knowledge. This first approach was used in Chapters Four and Five of this thesis, where the methods used in Phases One and Two of this research had very clear stages in the research processes. The second approach to presenting findings incorporates the discussion into the results section. In Phase Three of this research, the method used was a single case study with multiple data

sources. In order to fully describe the themes from these data sources, the second approach to presenting findings was employed in Chapter Six of this thesis.

3.4 Vulnerable research populations

This study focusses on exploring the experiences of people with mental illness. People with mental illness are a vulnerable group that continues to be marginalised in terms of government attention (World Health Organisation, 2010). Vulnerable groups are defined as social groups of people who have an increased risk of, or susceptibility to, adverse health outcomes (Flaskerud, 1998). Outside of the health arena, vulnerable groups of people "lack the ability to make personal life choices, to make personal decisions, to maintain independence, and to self-determine" (Moore & Miller, 1999, p. 1034). They are susceptible to harm, and require safeguards to protect their welfare and rights. People within these groups are often difficult to reach, silent, and hidden. They are the deviant, the tabooed, the marginalised, and the invisible populations within society (Stone, 2003).

Qualitative research methods are flexible and adaptable, and appropriate to understand meanings, interpretations, and subjective experiences of vulnerable people (Liamputtong, 2006). The concept of *sensitive research* is closely related to vulnerable group research. Sensitive research "requires disclosure of behaviours or attitudes which would normally be kept private and personal, which might result in offence or lead to social censure or disapproval, and/or which might cause the respondent discomfort to express" (Wellings, Branigan, & Mitchell, 2000, p. 256). Dickson-Swift, James, and Liamputtong (2008) recommended that researchers need to consider physical and emotional risk involved in sensitive research. In engaging people with mental illness in research, it is important to thoughtfully evaluate the research process to ensure it is appropriate, and then carefully determine the inclusion or exclusion of participants (Jacobson, 2005). Throughout the first and second

phases of the study, where people with mental illness were recruited as participants, care was taken to reduce any risk to participants. I was attentive to the issues surrounding research with people with mental illness from the planning stages of the research, and sought advice from partner organisations and referrers of participants about any vulnerabilities specific participants had in order to safeguard their involvement.

With regards to engaging people with mental illness in an inclusive approach in the first phase, I invited two participants who were interviewed to become research team members. The purpose of the research team was to perform thematic analysis of the interview transcripts. Further details of this method are provided in Chapter Four. I was explicit with the research team members about the value they brought to the research, quoting Maguire: "we both know some things; neither of us knows everything. Working together, we will know more, and we will both learn more about how to know" (Maguire, 1987, pp. 37-38). I ensured that research team members had opportunities to debrief in private and provide feedback to me if the narratives in the transcripts brought up any negative or difficult emotions. The research team members also had close contact with their psychosocial rehabilitation service providers during the period of working on the data analysis in order to ensure they had ample emotional and psychological support through the process.

Although the nature of the research questions in this study were not sensitive per se, I was mindful that participants may choose to disclose sensitive information. I ensured the research processes were in accordance with the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, 2007), and was careful about avoiding where possible any additional stress to participants with mental illness from research processes. In all interviews, I assured all participants that their confidentiality would be protected by removing all identifying features from their transcripts, including their names, names of friends, names of service providers, names of services they accessed, and suburbs that they mentioned which were close to where they lived. In one instance where a participant disclosed recent use of

illicit substances, and then expressed concern that I would report this to their service provider, I assured them that I would not mention this and would remove it from the transcript.

In instances where potential participants became unwell, I reassured them in telephone conversations that there was no pressure for them to participate, and that should they choose to, they would have the opportunity to be part of the study at later stages when they were well. In a situation where I judged that a potential participant was at risk of self-harm, I asked for permission to contact the service provider who had referred them to the study. Upon obtaining consent, I contacted the service provider, and discussed my concerns.

In order to deal with any emotional risk to myself, I kept a reflective journal to note any thoughts or feelings that were brought up during the research process. According to Warr (2004), researchers who are not provided the opportunities to debrief risk the possibility of carrying their research stories around with them, which in turn may be detrimental to their emotional well-being. Besides regular PhD supervision sessions, I also arranged for professional counselling to debrief as necessary.

3.5 Methodological rigour

I have attempted to improve methodological rigour of the research by embedding techniques into the research process. In accordance with Merriam's (2009, p. 211) criteria for qualitative studies; credibility, dependability, confirmability, and transferability were applied in all three phases to ensure the methodological rigour of the findings. This was important to ensure the findings of the research are trustworthy and the methodological decision-making through the research process was justified.

In order to be reflexive in data collection and analysis, I journaled my thoughts and feelings through the three phases of the research. Reflexivity is a process

of critical self-reflection on one's biases, theoretical predispositions, and preferences (Schwandt, 1997). It requires researchers to operate on multiple levels (Etherington, 2004), and acknowledges that the researcher is intimately involved in the setting, context, and social phenomenon he or she seeks to understand (Schwandt, 1997). Part of the reflexive process involved discussion with PhD supervisors and peers, reading relevant material, and reflecting critically upon potential bias by reviewing journal entries.

3.5.1 Credibility

Credibility deals with the question "How congruent are the findings with reality?" (Merriam, 2009, p. 213). Attention to credibility was given to the methods in all three phases through using research methods that were well established. Focus groups, in-depth interviewing, the Delphi study, and the case study are all well recognised and accepted methods. Progressive subjectivity is the monitoring of the researcher's own developing constructions, which is considered critical in establishing credibility (Guba & Lincoln, 1989). As mentioned above, I kept a reflective journal through the whole research process, which informed the research as it progressed. Discussions with my PhD supervisors and feedback from peers ensured that the methods used in all three phases were appropriate.

In Phase One, I engaged with partner organisations by participating in training sessions and meetings, as well as developing relationships with service providers and members of a non-government organisation's consumer reference groups in order to gain an understanding of the organisations and establish a relationship of trust. The focus group comprising consumer reference group members improved the credibility of the research as they assisted in developing the interview guide that was used in Phase One (b). Credibility was achieved through member checking (Lincoln & Guba, 1985) in the second meeting of the focus group and member checking of the interviews by the two researchers with lived experience of mental illness. Finally,

triangulation of methods, that is using focus groups and interviews in data collection, compensated for limitations in each method. According to Patton (2002), triangulation is used by qualitative researchers to check and establish credibility in their research by analysing a research question from multiple perspectives. By using two methods of data collection, the results could be checked between the two methods. In Phase Two, the iterative nature of the Delphi study reduced the likelihood of discrepancies in data because Delphi panellists performed member checking for each round. Credibility was further ensured by recording a clear decision trail that defends the appropriateness of the Delphi study to address the research question, choice of expert panel, data collection procedures, identification of justifiable consensus levels, and means of dissemination and implementation (Fink, Kosecoff, Chassin, & Brook, 1984). Triangulation via data sources, by using a range of panellists allowed individual viewpoints and experiences to be verified with others. After the final responses were distributed to panellists, I briefly interviewed two panellists who had clear understandings of recovery by telephone in order to gain feedback on the findings, particularly in relation to the applicability and credibility of the results. In Phase Three, site triangulation, or informants from different organisations, reduced the potential of any local factors affecting the study. Triangulation of methods, namely interviews and reviewing documentation provided contextual information and allowed clarification of themes.

3.5.2 Dependability

In order to ensure dependability, the processes within all phases of the research were reported in a thorough and detailed manner. Any modifications to the research methods were reported and explanations given about reasons for the changes. For example following Phase One, I amended the research design in Phase Two from a longitudinal study exploring pathways of vocation to a Delphi study to describe vocational recovery in mental illness. This was due to the emerging data that showed the importance of vocation for people

with mental illness and the distinct lack of clarity of what vocational recovery was. Phase Three was also redesigned as a single case study in order to answer questions that had emerged from the previous phases. Formal applications for these changes were made to Curtin University Faculty of Health Science's Research and Graduate Studies Committee and Curtin University's Human Research and Ethics Committee.

I made reflective appraisals of each phase of the research and provided recommendations on how they may be improved. For example in Phase Three, if the research had not been time-limited, it could have been improved by conducting multiple descriptive case studies with the new DES providers that had won the 2012 service tenders, as well as other mental health service providers in order to have a more in-depth understanding of the commonalities and differences in vocational recovery approaches and practices. In Phase Two, dependability was further ensured through documenting all changes in themes with each iteration of the Delphi study.

3.5.3 Confirmability

Through all phases of the research, confirmability, or objectivity was ensured through triangulation, as specified in the credibility section. A team approach to data analysis was used in Phase One and Two in order to reduce the risk of bias occurring. An audit trail was developed as a strategy for establishing research confirmability According to Creswell and Miller (2000), in order to develop detailed audit trails, researchers need to maintain logs of all research activities, develop memos, maintain research journals, and document all data collection and analysis procedures throughout the research process. Six categories of information need to be collected to inform the audit process, namely: raw data, data reduction and analysis notes, data reconstruction and synthesis products, process notes, materials related to intentions and dispositions, and preliminary development information (Lincoln & Guba, 1985). Appendix A represents a section of a combined reflective audit trail of

how my thinking has evolved and research audit trail of key methodological decisions.

Original transcripts, data analysis documents, my reflective journal, comments from member checking, and other auditable documents have been kept in accordance with National Health and Medical Research Council (2007) guidelines, and are available upon request.

3.5.4 Transferability

A detailed understanding of the phenomena in a particular case can form the basis for a better understanding of those phenomena in other comparable settings (Remenyi, 1998). Transferability to other settings is contingent on the similarity between the "sending context", or the context in which the research was conducted, and the "receiving contexts", the contexts to which the research findings are to be applied (Koch, 2006; Lewis & Ritchie, 2003, p. 268). To address transferability, I have provided throughout the thesis detailed description of the research context and theory upon which all phases of the study were based. Although the service and policy context in Western Australia lend this research to greater transferability within Australia, the findings of this research that relate to the vocational recovery in mental illness framework are strongly supported by theories of vocation and recovery in mental illness and will hopefully have relevance in an international context. Readers should be cautious in applying the findings in Phase Three to countries other than Australia.

3.6 Ethical considerations

Ethics approval for this research was granted from Curtin University's Human Research and Ethics Committee (approval number HR 116/2007) and the Department of Health's South Metropolitan Area Health Service Human Research and Ethics Committee (reference number 08/233).

Through the research process, ensuring participants were protected from harm was paramount. In sharing their stories of vocational journeying in Phase One and understandings of vocational recovery in Phase Two, participants chose to trust me with sensitive information, and in doing so, put themselves in a vulnerable position. In order to safeguard participants, clinicians and employment consultants acted as intermediaries in the recruitment process.

In accordance with the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, 2007), adequate information and documentation was provided to participants with regards to their consent and confidentiality. All participants were given information and consent forms in all three phases of the research. Information sheets were written in plain English and I explained the purpose of the research to all participants prior to data collection (see Appendices B, C, and G). Participants were made aware that they were at liberty to refuse to answer any question or may withdraw from the study at any time. Participants who were mental health service users were further assured that withdrawing from the study would, in no way, affect the services they received.

Privacy was a major ethical consideration in this study and when the study was completed, it was ensured that participants would not be identifiable. As previously noted, I removed all recognisable features from transcripts, including their names, names of friends, names of service providers, services they accessed, and suburbs that they mentioned were close to where they lived and worked. Although all participants within each focus group in Phase One were reminded of confidentiality, anonymity could not be guaranteed. The participants in the focus group knew each other prior to the research, and had close working relationships from being involved in the non-government organisation's consumer reference group. Focus group discussions and interviews were transcribed using pseudonyms and identifying features modified to protect participants' confidentiality. In Phase Two and Three, all responses were de-identified in presenting them to the panellists for comments.

The participants and research team in Phase One were paid for the time they spent on the focus groups, interviews, meetings, and data analysis tasks. Consideration was given to participants with mental illness with regards to the number of work hours per week to ensure their receipt of benefits would not be jeopardised. Participants in Phase One of the study received payment in money as compensation for their time; this payment was made following each interview or focus group session. Payments were made according to a partner organisation's consumer payment schedule. The research team in Phase One were also paid for their work, and this was made according to the Curtin University schedule of payments for casual research staff.

Audio recordings of focus groups and interviews were completed with the consent of participants (see Appendices B, C, and G for consent forms). Once transcribed, recordings were kept electronically in a password protected folder. Personal information was de-identified and stored securely in a locked cupboard in the School of Occupational Therapy and Social Work at Curtin University. Data will be kept for a minimum period of seven years.

3.7 Conclusion

This chapter outlined the methodological design of the study and outlined the research processes of the three phases. The theoretical underpinnings of the qualitative methods used in the study were summarised. The trustworthiness of the study has been discussed in terms of credibility, dependability, confirmability, and transferability. Finally, ethical considerations of the study were outlined.

The next three chapters describe each of the three phases in detail. Specific methods used in each of the three phases are presented, which include a more detailed account of settings, a description of the participants, and details of the methods used in analysis of the data. Results and discussion of the findings of each phase are also presented.

Chapter 4: Exploration of Vocational Aspirations and Experiences of People with Mental Illness

4.1 Introduction

This chapter and the two that follow present the major findings of the thesis. While the broad methodological foundations were discussed in the previous chapter, each of these three chapters details the methodological background, methods, findings, and discussion for each of the three phases of the study. This chapter discusses the first phase of the study and addresses three key questions. First, I explore the vocational aspirations for people with mental illness, where vocational aspirations are defined broadly as a person's ideal job, their vocational interests, career path, or vision of what they see themselves doing. Second, I seek to understand and document the vocational journeys of participants who, in this stage of the study, are people with mental illness. By vocational journeys, I mean the pathways by which people transition through their personal vocational life courses. Third, I explore the facilitators and barriers people with mental illness experience in their vocational journey, and how these impact on paths and services chosen by them.

4.2 Research Methodology

4.2.1 Inclusive Research

This stage of the research is informed by an inclusive research approach. Inclusive research was a term coined to shorthand the various strands of research in which people with learning difficulties have been involved as active participants (Walmsley, 2001). Inclusive research has been defined as a range of research approaches that traditionally have been termed *participatory*, *action*, or *emancipatory* (Freire, 1972; Walmsley & Johnson, 2003). Such research involves people who may otherwise be seen as subjects for the research as instigators of ideas, research designers, interviewers, data analysts, authors, disseminators and users (Walmsley & Johnson, 2003).

In keeping with this definition, a wide range of variations may be found within inclusive research frameworks (Ward & Simons, 1998). Inclusive research involves the researcher forming relationships with both individuals and organisations based on ideas of normalisation (Walmsley, 2001), where people with the lived experience of mental illness, in this instance, take on the valued social roles as co-researchers. Throughout my research I sought to collaborate with people with mental illness, and in the planning of this phase, worked closely with consumers to shape the research proposal.

Traditionally inclusive research requires that participants have part-ownership over the research agenda through being involved in one or more of the following: consultation in framing the research questions, developing interview questions, data analysis, and discussing and disseminating the findings. This was true within my research where the research questions were partly informed by discussions with consumer-consultants in partner organisations. I outlined the research relationship with the consumers and the partner organisations in Chapter Three. The development of interview questions and data analysis were also performed by research teams where consumers had roles as researchers, and were paid for their expertise. However, due to a number of tensions regarding ownership of the research and decision-making, which were inherent in a research project where I was required to demonstrate the ability to fulfil the requirements of a higher degree, I cannot lay claim to the research being fully inclusive. As this phase of the study was part of a PhD project, I adhered to as many of the principles of inclusive research as possible, whilst ensuring that Curtin University's criteria for successful completion of the degree were still met.

However, as many of the policies and practices which frame the rights of vulnerable populations, such as people with mental illness, are based on research, inclusive research provides a way for people to have a voice. I aimed wherever possible throughout this phase to present participants' views authentically. With the help of my co-researchers, who included people with

lived experiences of mental illness, I used critical reflection to assist me in being faithful in describing the essence of their lived experience of vocation.

4.2.2 Phenomenology

The intention of the first phase of the study was to understand and document as far as possible the vocational aspirations, achievements, and challenges of a group of people with mental illness. A phenomenological approach was used in order to study the lived experience.

The purpose of phenomenological research is to understand and explain the experiences of participants, or phenomena, as they are lived by participants (Crotty, 1996). Phenomenology involves gaining access to the phenomena and gaining a thorough understanding of the phenomena, in order to make their meanings clear. According to Heidegger's 1927 book, *Being and Time*, the ancient etymological roots of phenomenology are from the Greek words for light: *phōs;* and discourse, speech, or reason: *logos* (Heidegger, 1962). He then defined phenomenology primarily as a method "to let that which shows itself be seen from itself in the very way in which it shows itself from itself" (Heidegger, 1962, p. 58).

Although phenomenology was originally developed by Husserl (1859 – 1938), Heidegger's mentor, the term phenomenology had been used earlier by Hegel in *Phenomenology of Spirit* (Hegel, 1807) and Kant in his 1781 book *Critique of Pure Reason* (Kant, 1996). The core philosophical basis of Husserl's approach was a rejection of anything more fundamental than experience. He defined experience as a system of interrelated meanings, or a *gestalt*, that is bound up in a totality of the lifeworld (Husserl, 1936/1970). The lifeworld, or *Lebenswelt*, comprises the world of objects around us as we perceive them and our experience of our self, body, and relationships. For Husserl, phenomenology studies conscious experience from the subjective or first person point of view. Subsequently, Heidegger (1927/1962), Merleau-Ponty (1962/1996), and Sartre (1958) developed existential and hermeneutic (interpretive) dimensions of

phenomenology, which emphasised the lifeworld. According to Dahlberg, Dahlberg, and Nystrom, "the overall aim of lifeworld research is to describe and elucidate the lived world in a way that expands our understanding of human beings and human experience" (Dahlberg, Dahlberg, & Nystrom, 2008, p. 37)

In phenomenology, methodology represents the philosophical framework which must be assimilated so that the researcher is clear about the assumptions of the methodology (Van Manen, 1990). The research design for Phase One was a narrative approach that incorporated inclusive methods to working with people with mental illness. I wanted to understand the participants' experiences of vocation as a lifeworld. In approaching the interviews, I was reflective of the differences between my lifeworld and those of participants, especially those who were not meaningfully employed. I was mindful of how vastly the onset of mental illness changed participants' lifeworlds, and was empathic of the difficulties they experienced in their personal recovery and vocational journeys.

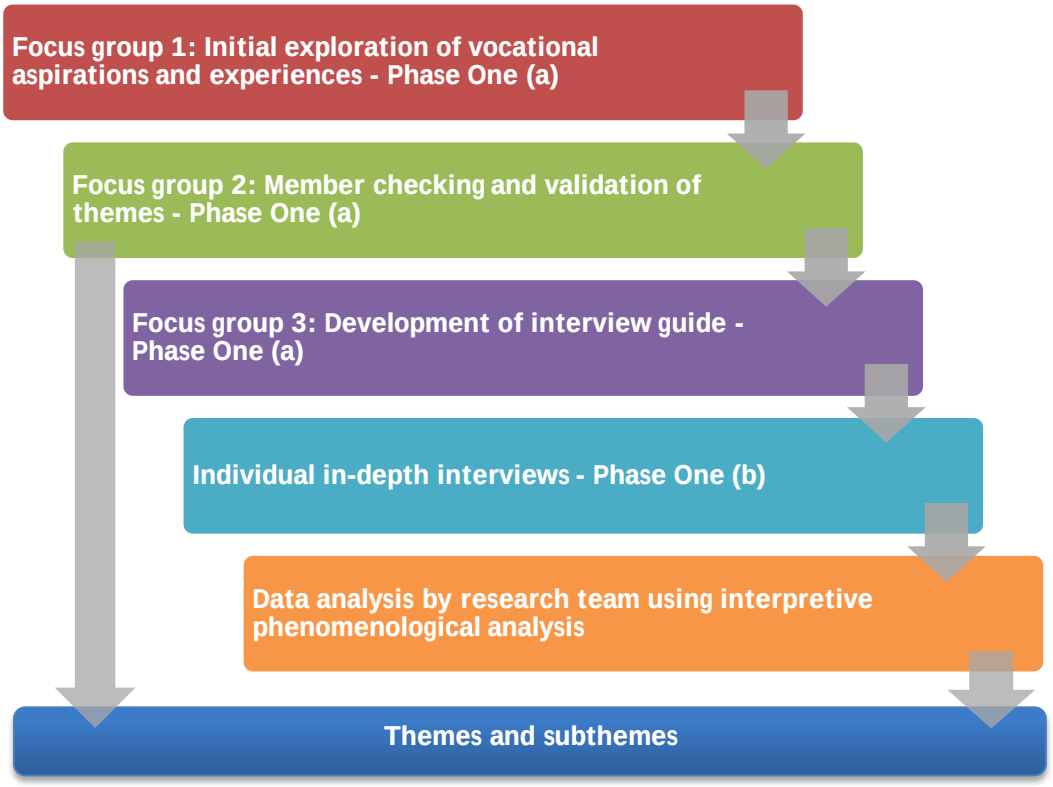
4.3 Method and Results

4.3.1 Overview of Phase One

Phase one comprised two discrete data collection stages: Phase One (a) and Phase One (b) that were conducted sequentially. Informed by an inclusive research approach, a literature review, and consultation with partner organisations and academic supervisors, this phase of the research involved discussion with people with mental illness through focus groups to discuss the research questions and develop an interview guide. The interview guide was intended to help focus the interviews with people with mental illness, and not provide an exhaustive list of questions to be asked in the semi-structured interview in Phase One (b) (Osborn & Smith, 2003). It was constructed in order to allow flexibility and fluidity in the areas that were covered. The focus groups were used to collect preliminary data on lived experiences of vocation

and facilitate discussion, whilst allowing spontaneity in conversation. Following the focus groups, Phase One (b) involved in-depth interviews that were conducted with a different group of participants to explore their experiences of vocation, understandings of what vocation means, and aspirations. Data analysis was performed using a team approach which will be discussed further below. Figure 4.1 depicts the methods used in this phase of the study.

Figure 4.1: Overview of the methods used in Phase One



4.3.2 Phase One (a) data collection: Focus groups

Focus groups are defined as "a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research" (Powell, Single, & Lloyd, 1996, p. 499). This method can be used during the initial stages of a study to develop questions or concepts for questionnaires and interview guides (Kreuger, 1988). Focus groups were used in the initial phase of the research to elicit a collection of experiences, feelings, beliefs, and attitudes about vocation. This enabled me to

gain a large amount of information in a short period of time, which shaped the interview guide that was used in the subsequent face-to-face interviews.

4.3.2.1 Development of the interview guide

The focus group comprised mental health consumers from a specialist mental health DEN provider. I attended the partner organisation's consumer reference group meeting in order to introduce myself and present my proposed research. Through this meeting, I obtained expressions of interest from consumers who were interested in participating in the focus group. I decided to recruit mental health consumers through the consumer reference group, because they were experienced in issues surrounding vocational services for people with mental illness. Seven consumers expressed interest and, upon telephone follow-up, three participants formed a focus group. All three participants were employed at the time of the research. The other consumers who had expressed interest in the research were unable to participate due to being unwell (one consumer), being time-poor (two consumers), and having difficulties attending focus group sessions due to transport difficulties (one consumer).

The focus group had two objectives: 1) an initial exploration of vocational aspirations and experiences of people with mental illness, and 2) to develop and refine a semi-structured interview guide. These two objectives were met in three two-hour focus group sessions, over a period of three weeks. The focus group met in a meeting room at the specialist mental health DEN provider. All sessions were digitally audio recorded and I took written notes. After every session, I checked the accuracy of the written notes with the audio recording. Focus group members were paid $20.00 in cash at the end of each session to cover out of pocket expenses for participation in the research study. This amount was based on the specialist mental health DEN provider's schedule of payments for consumer involvement.

4.3.2.2 Focus group meeting one

One week prior to the first session, I sent agendas to the focus group members so they could reflect upon the discussion points in preparation for the meeting. Points for discussion were included in the agenda, specifically:

- What is your lived experience of mental illness?
- How would you define vocation and how may vocation be manifest in the lives of people with mental illness?
- What are examples of vocational aspirations? How would we structure questions to gain information from participants on their goals?
- What are examples of facilitators and barriers to vocation? What questions may be used to explore facilitators and barriers in depth?
- How do people make choices about vocational paths? What influences their decisions?

In the first session, I reintroduced myself, described the aim of the group and the purpose of the research, and followed this by leading a discussion of concepts and meanings of vocation. Group members shared their personal experiences of mental illness and vocation. Ideas were generated on vocational experiences, and potential facilitators and barriers to attaining one's desired vocation. Following the first session, I reviewed the audio recording and notes. From these, I noted emerging themes based on the points for discussion, and clustered the themes into a list, which was referred to in the next session and formed the basis of the development of the interview guide.

During this first group, all three participants shared stories of their individual vocational experiences and how these experiences had shaped their vocational journeys. The themes and subthemes from this session were combined with the themes from the individual interviews in the data analysis stage of this phase.

4.3.2.3 Focus group meeting two

In the second session, focus group members reviewed the table of themes (Table 4.1) to confirm its accuracy in a member checking exercise. Each theme was written on a card, and these were distributed randomly on a large table, with focus group members sitting around it. Themes were then clustered together using a card sort method (Morse & Field, 1996), where cards with similar themes were put in the same pile. The card sort was accompanied by discussion on which themes belonged together and why. Similar themes were combined and redundant themes, removed, until consensus was reached by all group members. Following this, questions were formulated from the themes by the group. For example, from the themes about vocation, the question formulated was: When you think about the word vocation, what does it mean to you? Subsequent to the second meeting, I printed the questions onto individual cards. These cards were used in the third meeting to order the questions in the interview guide.

4.3.2.4 Focus group meeting three

In the third meeting, consensus was reached through discussion and sorting about the order of the questions in the interview guide. The order of questions was important in attempting to reflect a natural flow of interviewees' stories. Less personal questions about vocation were first in the sequence of questions, with potentially sensitive questions placed later. Essential questions, extra questions, and probing questions were generated. Further to this, there was discussion around using language that was familiar to the participants and how to deal with potentially sensitive issues.

The interview guide was reviewed by the group using a guide developed by Chadwick, Bahr, and Albrecht to ensure that:

- All of the questions necessary to inform the research question had been included;
- The questions elicited the types of responses that were anticipated;

- The language was meaningful to participants; and
- It engaged participants and motivated participants to continue with the research study (Chadwick, Bahr, & Albrecht, 1984, p. 120).

4.3.3 Phase One (a) Results

Discussion in the first focus group yielded themes about notions of vocation, including aspirations and choices; motivators for working; emotions from losing one's job with the onset of mental illness; and coping mechanisms people had developed. Table 4.1 lists the themes and the subthemes that were identified. Some of the themes were drawn from the in-depth interviews, and were incorporated into the larger list of themes.

Table 4.1 Themes from focus group meeting one.

Themes	Subthemes		
Vocation	Roles	An expression of who you are	Use of talents & skills
	Education: apprenticeships/learning	Challenge & reward	Do willingly: paid/unpaid
	End point of chosen career path	Experience	Qualifications
Vocational aspirations	Embracing ideas of having choice	Journey of recovery	Conversations about the future
	Being respected & heard	No limitations	Nature of work
Vocational choices	Personal strengths & weaknesses	Trial & error	Exploration & learning
	A sense of belonging	Limited due to being unwell	Self-esteem & confidence
Why I want to work	Money	Self-esteem	Independence and autonomy
	Social validation	Learn lessons	Self-acceptance
Emotions	Anger	Anxiety	Fear

with losing a job	Mistrust of employers	Invalidation of self	Retreating from world
Coping mechanisms	Employment consultant	Humour	General practitioner
	Support	Positive reinforcement	Family & friends
	Meditation	Time out	

Many themes from the focus groups have close association with themes from the interviews which will be discussed later in the chapter. Notions of vocation were similar, in that focus group members described vocation in terms of a meaningful activity that led to a career path, an expression of one's authentic self, and using one's skills and talents. They saw work as a subset of vocation, which was linked to valued roles. Vocational aspirations were closely tied in with vocational choices, and participants valued the experience of having opportunities to explore and learn as part of the process of job seeking with the support of their employment consultants. They regarded these experiences as part of their recovery journeys. Although recovery was a subtheme that emerged from the focus groups, I categorised it as a background concept at this stage of the research.

All focus group members had work histories of being employed in three or more different jobs subsequent to being diagnosed with mental illness. They described their experience of mental illness and how it related to employment situations. Feelings of anxiety, anger, and mistrust led to the participants retreating from society. All participants experienced stigma in the workplace, which then led to experiences of invalidation.

In order to cope with workplace pressures, participants relied on support from clinicians, employment consultants, and family and friends. They also employed strategies, such as having time-out, meditation, and having a good sense of humour in order to remain positive.

Besides earning a living, which brought independence and autonomy, participants identified social and personal validation and acceptance as reasons they wanted to work. The meaning they found in pursuing their vocation of choice improved their self-esteem.

These findings served to both inform the questions for the in-depth interviews and support the findings from the in-depth interviews, which are presented in a subsequent section.

4.3.4 Phase One (b) data collection: In-depth interviewing

The purpose of in-depth interviewing is for the researcher to attempt to understand the world from the participants' points of view in order to comprehend the meaning of their experiences (Kvale & Brinkmann, 2009). This dialogue between the researcher and the participant centres on the participant's perception of self, life, and experience, as expressed in his or her own words (Minichiello, Aroni, Timewell, & Alexander, 1995). Participants in this phase of the research were interviewed using an individual in-depth interview format, focusing on each participant's personal vocational experiences. In-depth interviewing was chosen as the process of telling their individual vocational journey stories. It gave participants a voice and produced rich narratives to inform the research.

4.3.4.1 Finalising the interview guide

I conducted two practice interviews with academic colleagues to pre-test the interview guide and gain familiarity with the questions. Subsequently, I piloted the interview guide with a registered psychologist who had experience working as an employment consultant, a mental health service provider, and a consumer consultant to identify blind spots, bias, and potentially sensitive questions. After final modifications to the interview guide, I used it to guide the in-depth interviews that followed. The questions in the interview guide used in Phase One are listed below.

- What is your vocational history? For example, can you tell me a bit about the highlights of work, volunteering, education, or training experiences?
- When you think about the word vocation, what does it mean to you? *(When you think about the word aspiration/ambition/dream, what does it mean to you?)*
- What's your experience in choosing what you want to do in life? (*in terms of vocation*) (*probes: money, experience, education*)
- If these were not a concern, how would your choices be affected? *(If by some chance you inherited enough money to live comfortably without working, do you think you would work anyway?) If person would work, ask why he/she would feel the need to do so.*
- It may sound obvious, but why do you want to work?
- What sort of work do you believe you're able to do?
- *If working***:** Suppose you didn't work, what would you miss most?
- Can I ask you a few more questions about yourself? I'm interested in how other things going on in your life might affect your choices.
- What are the things that make it easy for vocation/career/work/job/life choices?
- What has been good about your vocational journey thus far?
- What has been not so good about your journey?
- What suggestions do you have that could have made your journey better?
- What are your living arrangements? How often have you moved and why? (*If person has had housing problems, explore how this has affected their vocational capacity and experience).*
- How has your health been? Have you had any health concerns*? (If person has had health problems, explore how this has affected their vocational capacity and experience).*
- Some people have difficulties that aren't obvious which make it harder for them to look for work. Do you have any barriers to vocation?

(*Explore how these problems have affected their vocational capacity and experience).*

- Where do you hope to go from here in terms of your vocation?

4.3.4.2 Participant selection

English speaking mental health service consumers between the ages of 18 and 65 who were engaging in vocational activities including active job seeking, performing a work trial, or participating in work were recruited using purposive convenience sampling. Letters of invitation, information about this phase of the study, and my contact details were distributed to consumers via government mental health agencies and non-government community organisations (Appendix B). These organisations included a specialist DEN provider and a community-based mental health service. I attended staff meetings within these organisations to present the proposed research and detail the inclusion criteria for participants. Occupational therapists and employment consultants from these organisations identified potential participants within their services and approached them directly about being involved in the study. Further to this, they obtained permission from interested consumers to give me their contact details. I contacted potential participants directly by telephone to give them information about the study, and organised mutually convenient times and places to conduct the interviews.

According to Smith, Flowers, and Larkin (2009), six participants are considered a reasonable sample size to provide sufficient perspective with adequate contextualisation in a purposive and homogenous sample. As participants at differing stages of their vocational journeys were recruited, it was anticipated that more than the recommended sample size would be required to capture any differences between participants. Participants could include people who had been unemployed and unengaged in vocational activities, but wanted to re-engage in vocational activities; or people who were

actively engaged in vocational activities either through seeking employment, volunteering, participating in education or training, and being employed. Data analysis was performed concurrently with interviews to identify emerging themes and determine saturation of data. Recruitment of participants continued until saturation occurred, where there was repeated evidence of emerging themes.

Twelve participants were recruited into the study; however, three participants were not interviewed due to illness, re-admission into hospital, and passing away. As such, nine participants contributed to this phase of the study (Table 4.2). All participants were of European descent, except one participant, who identified as being Aboriginal. Three participants had a primary diagnosis of major depression, three had bipolar affective disorder, two had schizophrenia or a psychotic disorder, and one had borderline personality disorder. All participants had experienced periods of hospitalisation when they were most unwell. In order to protect the identity of participants, pseudonyms have been used.

Table 4.2: Description of participants

Participant	Sex	Age	Living arrangements	Participant's engagement in vocational activities (a distinction is made between whether participants wanted paid work or work that was meaningful and purposeful for them). These categories were not mutually exclusive.
Sonia	F	39	With one child	Wanting paid work after many years of unemployment; about to engage with a DEN provider
Shelly	F	48	With three housemates	Actively seeking paid, meaningful work; completed training courses in specified field

Tim	M	39	With parents	Engaged in full-time paid, meaningful work, obtained work without assistance from vocational service providers
Linda	F	51	Alone	Seeking paid work, in the process of negotiating a part-time position
Georgie	F	33	With one child	Seeking paid work after being unemployed for many years, awaiting a referral to a DEN provider
Adam	M	55	Alone	Engaged in full-time paid, meaningful work after attending a position-specific training course
Nell	F	48	Alone	Volunteering part-time, and seeking paid, meaningful work after recently being unemployed
Marcus	M	52	Alone (two children live independently)	Seeking paid work with the assistance of a DEN provider
Ivan	M	43	Alone (three children visit once/fortnight)	Aspired towards meaningful work, but seeking paid work with the assistance of a DEN provider

4.3.4.3 Data collection: Interviewing participants

In-depth interviews were conducted with participants from 13th August 2008 to 14th November 2008. I contacted participants by telephone to schedule interviews. During these telephone discussions, participants were briefly informed about the nature and focus of the interview and verbal consent was obtained to audio record interviews. Face-to-face semi-structured interviews were conducted at a time of each participant's choosing in convenient

locations within the Perth metropolitan area. Venues included a mental health service, participants' homes, and Curtin University.

I started each interview by introducing myself and detailed the purpose of the interview, which was to learn about each participant's vocational experiences. I gave the participant an information sheet and consent form (see Appendix B), and provided verbal information on how the information from each interview would be used and how participants' confidentiality would be maintained. Participants were encouraged to read the material provided and to be forthright with any questions they had before signing the consent form. I also used this pre-interview period to develop rapport with each participant in order to allow the participant to feel at ease, so as to obtain higher quality information (DiCicco-Bloom & Crabtree, 2006).

Following informed consent, individual interviews lasting 50 to 120 minutes were conducted. Interviews were digitally recorded and transcribed verbatim. In order to approach the research questions from the participants' points of view, the semi-structured interview guide with adjusted language and unscheduled probes that arose from the interactions in the interview process, was used (Berg, 2004). Subsequent to each interview, I reviewed the audio recording, and made initial reflective notes on the themes that emerged. This was performed in order to determine data saturation, where no new themes emerged. Although I had anticipated vastly differing themes from each of the three categories of participants, in conducting the interviews, all participants gave similar responses to many of the questions, regardless of whether they were pre-vocational (or engaging in activities in preparation for pursuing a vocational role), pursuing a vocational role (or engaging in job-seeking and exploratory activities), or maintaining a vocational role.

4.3.4.4 Data analysis

A research team was formed, comprising two participants with lived experience of mental illness, an academic with a social work background, and

myself. Both research team members with mental illness were successful in pursuing and attaining their vocational aspirations, and were recruited through participation in the interviews in Phase One (b). They both had success in maintaining lengthy meaningful employment in their chosen vocation and volunteered for the positions because they felt they could contribute to the project. The purpose of the research team was to analyse the interview transcripts in order to uncover the themes about vocation for people with mental illness. The two participants with lived experience of mental illness also assisted in member checking the responses.

A hermeneutic variant of the phenomenological method is Interpretive Phenomenological Analysis (IPA) (Osborn & Smith, 2003). This variant emphasises the researcher's role and possibilities of interpretation. It involves detailed examination of the participant's life-world, attempts to explore personal experience, and is concerned with an individual's personal perception or subjective account of an object or event (Osborn & Smith, 2003). The focus of the research was: "What is the individual experience of vocational journeying when one has mental illness?" Once the narratives from interviews had been collected and the analysis begun, the aim was to capture individual variations within the research team, with thematic analysis involving some explicit interpretation on the parts of researchers. In accordance with Osborn and Smith (2003), this was achieved through two levels of interpretation. Firstly, the participants offered their interpretation of the phenomenon and associated thoughts and meanings via their language; and secondly, the researchers attempted to understand the participants' comments. In order to be able to understand the lifeworld experiences, each researcher was directed to be as open and free of assumptions as possible and to bracket their pre-existing theoretical understanding during the analysis of interview transcripts. The research team comprised two researchers with lived experience of mental illness who were particularly empathic in understanding participants' lived experiences. They played a central role in ensuring the voice of people with mental illness was validated as data.

The following step-by-step data analysis guide was adapted from Smith et al. (2009) and was used in this phase by the research team:

Step 1 Reading and re-reading – immersing oneself in the original data.

Step 2 Initial noting – free association and exploring semantic content (e.g. by highlighting statements that appeared relevant to the research questions and writing notes in the margin).

Step 3 Developing emergent themes – focus on chunks of transcript and analysis of notes made into themes.

Step 4 Searching for connections across emergent themes – abstracting and integrating themes.

Step 5 Moving to the next case – trying to bracket previous themes and keep open-minded in order to do justice to the individuality of each new case.

Step 6 Looking for patterns across cases – findings patterns of shared higher order qualities across cases, noting idiosyncratic instances.

Step 7 Taking interpretations to deeper levels – deepening the analysis by utilizing metaphors and temporal referents, and by importing other theories as a lens through which to view the analysis.

Data analysis through IPA resulted in generation of rich interpretations of the phenomenon that was context-specific and inclusive of both the participant and the researchers, namely, the experiences of the participants and their common experiences with various stages and pathways in vocational journeying.

I conducted a three-hour training session on IPA prior to data analysis. This session involved an explanation of the process of data analysis, an in-depth discussion of how each member would contribute to the analysis, a practice run of performing IPA on a transcript which was not part of the research. All members of the research team were given written instructions on the data

analysis process. Table 4.3 shows the guide used by the research team in analysing data.

The research team met in three rounds to discuss themes from the interviews. Transcripts were divided into lots of three. I analysed all nine transcripts and each of the other three members of the research team analysed three transcripts each. In this way, each transcript was independently analysed by two members of the research team.

In each round, emerging themes were identified and considered in terms of connections and relationships between them. The team verified each emergent theme back with the text itself. Each researcher's analyses of themes were compared in a group meeting involving all researchers to clarify interpretations of findings and list emergent themes. The meanings that emerged from the meetings were clustered together as themes and subthemes in order to better to understand and describe their interrelationships.

Table 4.3 Guide to the steps in IPA used by the research group

Individual Analysis
Step 1: read whole transcript Aims: ▪ acquire a sense of each transcript ▪ become as familiar as possible with each account
Step 2: a) highlight significant statements and phrases pertaining to the research questions b) In margins: comment on items of interest or significance such as preliminary comments and interpretations of the text including similarities, differences, echoes, amplifications, contradictions, and emerging themes
Discussion (between two researchers who had reviewed the same transcript)
Step 3: a) Comparison and listing of themes – emergent themes are discussed

and listed chronologically (based on sequence they come up in transcript) b) Clustering of themes and rechecking in transcript and compiling directories of participant's phrases that support related themes
Group Analysis (all four researchers)
Step 4: a) discuss themes from analysed transcripts b) compare and cluster themes and subthemes

Second and third rounds of group analysis meetings included referral back to the list of themes and modification of the list of themes and subthemes according to how newer themes related to them. In this way, the emerging themes and subthemes were refined as a single list from one participant to the next. Following the final group meeting, I integrated the results from the list of themes from the focus group and the interviews into a rich interpretation of lived experience by converting the list to a narrative, as presented in the next section of this chapter.

4.3.5 Phase One (b) Results

In understanding participants' vocational experiences, the metaphors of journeys and paths chosen were useful in identifying their motivations, aspirations, and facilitators and barriers that may have affected their decision-making processes. Although interview participants were at different stages of their personal vocational journeys, many responded with similar stories about what vocation meant to them, how their personal recovery journeys were important, and the facilitators and barriers they faced. All participants were candid in the interview and shared their personal stories of difficult times, as well as how they found ways to continue with their lives by being resourceful and resilient. One noteworthy finding was that personal recovery in mental illness was described as central to successful vocational journeys. This finding

led me to reconsider vocational journeys in terms of recovery theories, and from this reflection, Phase Two of this research was developed.

The findings of this phase are organised into five themes and seven subthemes that describe the vocational experiences of people mental illness. These themes are: the personal and social sequelae of mental illness; vocation; barriers to vocation; facilitators to vocation; and vocation in the context of recovery journeys. The five themes were separate investigations of the different aspects of vocation and the lived experience of mental illness. During the focus groups and individual interviews, participants shared their personal experiences of having mental illness and how that affected their lives, relationships, and roles. They described what vocation meant to them and discussed the facilitators and barriers they faced. Finally, the participants who had been successful in maintaining their chosen vocation spoke about their personal recovery journeys. Table 4.4 lists the themes and subthemes of this phase.

Table 4.4 List of themes and subthemes

Theme	Subtheme
The personal and social sequelae of mental illness	Perceived experience of being devalued, rejected, and isolated
	Self-stigma negatively affecting participation, identity, and self-worth
Vocation	The meaning of vocation
	Vocational aspirations and choices
Barriers to vocation	Personal factors and loss of valued life roles
	Restrictions in employment opportunities
Facilitators of vocation	Formal supports
	Informal supports
Vocation and Recovery	

Theme One: The personal and social sequelae of mental illness

Perceived experience of being devalued, rejected, and isolated

Participants used the words "neglected", "isolated", and "abandoned" to describe the deep hurt they felt from the loss of personal relationships following the onset of mental illness. All, save three participants, experienced rejection from family and friends when they were unwell, which led them to withdraw or "retract from the world".

All participants experienced being labelled as having a mental illness, which led to subsequent stigmatisation through personal interactions, as well as by the public. These negative experiences and devaluations contributed to personal wounding. Tim explained that it was not realistic to expect the general public to understand mental illness as "it's not common knowledge, it's folk knowledge". His view was that it was unrealistic to expect people to know all the things he had learnt about mental illness without lived experiences of it.

Public stigma was experienced through devaluation, rejection, and feeling "like an outcast due to mental illness". Linda and Shelley both struggled with this prejudice. Linda stated: "It's really hard out there. And people don't know how to accept us as ordinary people". According to Shelley, "Every time I've felt that someone has been looking at me as just an illness, and I felt really judged and devalued, and sometimes even condemned, I have always withdrawn and I have always regressed".

Georgie spoke about "the stigma of the aboriginal people… you get followed around in the shops", which intensified symptoms of anxiety and paranoia that she experienced from mental illness.

With repeated encounters of discrimination, participants experienced gradual withdrawal from social situations. All participants described living in relative isolation, with only a handful (if that) of social or familial contacts. Ivan

explained his feelings of hopelessness in this matter: “I miss the interaction with people. But then like right now, I fear the interaction with people”.

Self-stigma negatively affecting participation, identity, and self-worth

All participants described a loss of a sense of identity and having to *“put on a mask”* to interact with society following mental illness. Linda described feeling like she was only her diagnosis, and having to justify who she was to herself: “you get slapped with a label and think: ‘is that *what* I am… and that’s not *all* I am. I’m also…’”

Shelly and Adam described their own stigma about mental illness, the power difference that still exists in the mental health system, and how their self-identities were affected. According to Shelley:

> If you were a nutter you weren’t worth anything and you know, to be ridiculed and put down and disregarded and devalued… And once you develop a mental illness yourself, you put yourself in that position of being. I have a mental illness, therefore I deserve to be disregarded and devalued. If somebody in the mental health system scorned me and told me I was just being lazy and stuff, then I tended to believe it.

Adam echoed her sentiments:

> I don’t know I’ve ever experienced stigma unless it’s myself doing it, because I didn’t know I had a mental illness and that’s why people stigmatized me in the first place. I’ve only ever felt it from professionals sometimes, who do this kind of thing where ‘we know what’s going on, because we’ve been to university about it’. I’m very glad that people have and they have some insight but, the only other stigmatisation I felt has come from myself from what I believe society thinks in terms of you won’t be able to get a job – you’ve got a mental illness.

Theme Two: Vocation

The meaning of vocation

In terms of describing their understanding of the meaning of vocation, only two participants spoke exclusively about paid work and having a job. Other participants' definitions of vocation encompassed more than just paid work or employment. Their responses indicated deeper and more personal beliefs of pursuing aspirations, doing what one is called to do, and fulfilling one's dreams. To Sonia, it was "as broad as your life purpose". Participants described vocation as being more than educative, volunteer, or employment activity. They ascribed a high value to choice in vocational activity, and described it as productive, meaningful, challenging, and rewarding.

To Adam, and other participants who were actively job seeking, vocation was an expression of his values and beliefs:

> Something you feel you are chosen to do. Something that is bigger than a job to pay money… Something that gives your life meaning, something you're going to devote a large part of your time and yourself to, and something you enjoy doing.

Although earning money was a reason participants wanted to work, they all said that if they were in a situation where they were not required to work for financial reasons, they would still choose to participate in vocational activities. For participants, being able to use one's talents and skills encouraged self-expression and contribution to building an authentic self. Participants described vocational activities as a means of self-development, and building an authentic self. Through engaging in vocational activities, participants re-established roles and re-crafted their identities following the disruption in their school or work lives from mental illness. For many participants, vocational activities were based on their personal preferences of what held meaning and ignited passion in them. Shelley held this view strongly: "Rather than just the money side of it, I want to be doing something that's meaningful for me. And purposeful".

Vocational aspirations and choices

Questions asked of the participants that related to describing vocation and their experience of choosing what they wanted to do in life yielded information about their vocational aspirations and choices. In responding to these questions, all participants had a clear sense of what they would like to do if earning a living was not a major concern. Seven of the participants identified vocational aspirations as a way to contribute, be involved, or "give something back" to mental health groups and services. Tim described being fulfilled from his contribution to a support group in being able to: "say to people look there is an end, there can be an end to this, it can get better".

In some cases, vocational aspirations differed from the vocational path they were pursuing at the time of the interview. For example, vocational aspirations were based on individual choices and preferences, whereas the vocational choices that many participants made were limited by the work their employment consultants were able to secure for them within the constraints of the system. Five out of the nine participants aspired to be peer support workers, and of these, only one was working in that capacity and another participant was in the process of obtaining employment as a peer support worker. However, the others were considering more practical jobs like stacking shelves or meter reading because they were the jobs that were available to them. Some participants saw these more modest jobs as a first step to re-entering the workforce and were content with that. Nell spoke about the narrow choices she experienced due to the limitations she experienced from being unwell:

> I think vocation is where you want to be. What you really want to work as. And I don't think I've ever really had that. I've had jobs... I wish I could get a part-time job. I don't even care doing what anymore. I just need a bit of extra money. The pension is hard to live on at the moment.

All participants recognised that they needed to both explore various options and learn from their experiences in order to choose meaningful vocations. They accepted that trial and error in terms of work placements were necessary steps in obtaining longer-term employment. However, participants also indicated that they were far more motivated to aspire towards their chosen vocation if they felt they were listened to and truly heard and respected in conversations they had with employment consultants and service providers about their futures.

Theme Three: Barriers to vocation

Personal factors and loss of valued life roles

Seven participants experienced losing their regular jobs with the onset of mental illness. They spoke of fear, anger, and anxiety with the loss of their jobs, which led to feelings of invalidation and retraction from the world. Some participants spoke of having a growing mistrust of employers due to traumatic and hurtful experiences at work that were linked with their first episode of being unwell. For example, Ivan described his first episode of bipolar disorder. "I actually wrote a letter to my boss explaining all the problems with his company (laughs) and they sacked me the next day, which I'd never do". Marcus also recounted experiencing long hours at work and a large amount of work stress:

> Over a period of time it just caught up with me. Yeah, I mean I had a sales rep in, sitting in front of me in my office and I just had a great big panic attack. And ever since then I've not been able to face pressure. I will basically run away from being in that sort of environment.

All participants found the workplace a difficult environment to negotiate. They were nervous and uncertain about new work situations, and found that some symptoms of mental illness were exacerbated because of the added pressure of being in the workplace, where certain behaviours were not understood. Adam

gave an example scenario about office chit-chat around the water cooler that triggered feelings of paranoia about his colleagues criticising him behind his back. He continued to say that it took a considerable amount of clinically-supported personal work and effort for him to overcome this negative belief. Participants who were successful in attaining the vocations they aspired to benefited from ongoing psychosocial support during and following the transition to employment, in order to attend to stressors and potential difficulties.

For the participants who were actively seeking employment, these personal limitations caused frustration, as described by Sonia: "...and guess what stands in the middle? My mental illness. Right in the middle. Otherwise it wouldn't be a problem".

Participants described damaging wounding experiences from losses in valued roles that came with mental illness. Marcus described moving from being a worker to being a welfare recipient: "I've been working all my life, basically, and when I get crook I seem to get kicked, that's how it feels". He continued to describe feelings of shame: "And then you end up having to go and ask, cap in hand, for food vouchers from the Salvation Army".

The worker role was meaningful and rewarding for participants and this was most obvious when the participants reflected on the loss of meaning and reward. When asked what they missed (or would miss) most if they were not working, Tim's responses were shared by all of the participants: "I would miss the money, I would miss the social aspect, and I'd miss the satisfaction of doing something well".

Fractured relationships with the onset of mental illness caused wounding and feelings of being cast out from society. Being unemployed constrained the participants' ability to function in other roles such as provider, partner, parent, and friend. This in turn negatively affected their self-esteem and participation in valued occupations. Three participants experienced an irrevocable breakdown in their life partnerships during the onset of mental illness. This

had happened in Ivan's family life, and although his children used visit him almost every fortnight, he explained that his relationship with his children had become tenuous because he was not able to "do fun things with them, like go to the movies" due to the lack of money. This negatively affected his parenting role because his children had begun to choose not to spend time with him.

Restrictions in employment opportunities

All participants experienced restrictions in opportunities to participate in productive employment. Seven participants spoke of a lack of formal supports, poor linkages between services, or a lack of awareness of what employment services were available, which made it difficult for them to consider, let alone seek employment. They explained that there was a certain amount of chaos that mental illness brought, and information that may have been given to them about employment services was easily lost in the confusion and disorder when they were unwell.

Participants who were engaging in vocational activities at the time of the interview underwent difficult processes in terms of job seeking. They described negative experiences, such as staff not understanding their individual experience of mental illness, frustration with not being able to deal with the mandatory paperwork that was involved in obtaining a disability pension, and working with employment consultants who were not focussed on their preferences in job selection.

All participants described difficulties negotiating the employment application process in their journeys. Sonia's response reflected these feelings: "Anxiety. The whole thing just causes me anxiety".

Marcus experienced a lack of person-centred support with regards to service provision by employment consultants: "they don't have time to sit and listen to you. I keep knocking on doors and saying 'help, help, help', but it's not the individual person's fault, it's the system".

He pointed out that it can't always be about crisis intervention. Ivan expressed similar feelings, stating that some employment consultants were "really not understanding".

Ivan also described being discriminated against in an employment setting after disclosing he had a mental illness, despite having an employment consultant to assist in the process:

> I don't really like to tell people this happened to me. Some jobs I have… like the meter reading job. They asked me to do a supervisory role just to drive around. But once I put it [the mental illness] down, well they changed it to: "we can make you a meter reader".

All participants described tensions around the issue of disclosure due to the fear of being stigmatised. Those with employment consultants had had in-depth discussions about this subject. Tim spoke about the issues he experienced surrounding disclosure: "it's a fairly intimidating idea because you're asking that people know the actual reality of the situation – that it can be effectively managed, that it's **not** a deep flaw in your character".

Sonia underwent a dispiriting experience of a service provider suggesting that they pretend she didn't have a mental illness in job searching:

> Even with the employment agency I'm with now, I can feel the employment co-ordinator that I work with… feeling like they're almost trying to pretend I don't have anything wrong with me, cover it up. Like, "it's not obvious Sonia, you're not in a wheelchair, can't you just change your history a bit and say you stayed home to look after your son?"… and I'm like, "no" because even they are aware of the stigma, it's that bad.

Participants who were actively seeking employment reported difficulties in explaining the breaks in their work history due to periods of being unwell with mental illness. For participants, these periods ranged from two to twelve years, most with recurring periods of being unwell. Nell explained:

> I think the real bind is – I've been off work for a long time, and they want to know why... It's just hard with that huge gap. And you don't know what to say. You're not doing house duties. You've been ill, ill, ill, but you're better now or getting better and, some people are ok. But most people would prefer someone who's normal than take on the risk of someone who's been sick for such a long time.

Tim brought up another issue that could impair employment seeking: "how do you get referees when you walked out of the workforce telling everybody to go f*** themselves? Which is the sort of thing you do when you're manic".

Theme Four: Facilitators of vocation

Formal supports

Participants described mental health care service providers as being pivotal in influencing their recovery, which in turn affected their vocational journeys. Participants who attended DEN providers found that employment consultants who specialised in mental health were "crucial" to their vocational journeys.

Ivan relied on them to: "help me get through it. They guide me in that direction, and say: 'you'll be very good at it'... that's really encouraged me". "I think people ... actually listening and giving clear answers or responses or advice to what I am asking" was the dedicated support that Adam found helpful.

Adam also felt strongly that having support from service providers who understood that they were not just "engaging in with textbook concepts or a theory", but dealing with someone's life. Shelley supported this person-centred approach:

> When it's been that a person has accepted me as a person first, wanted to get to know me first as a person, and then looked at my issues **with** me, rather than just looking **at** me, and talked about it **with** me, rather

than talk **at** me, I have always grown. Sometimes in little bits, sometimes in leaps and bounds.

Informal supports

Participants who had family and friends described these informal supports as helpful in their vocational journeys. These were trusted people who understood and accepted them. For Tim, having family support was a godsend: "you're in a place where it's full of despair and hopelessness. So really that was where support from home came in. Having somebody saying to you: 'Look, it's going to get better. Just trust me'".

Linda relied on friends because:

> I'd be accepted if I did something I did wrong, like I couldn't remember, sometimes, or if I'm depressed I think other people around me would understand. I think that's the big thing. That's the biggest thing. So it will be like a safe zone for me. And I could talk to people.

Theme Five: Vocation and recovery

For participants, vocational activity resulted in personal interactions, which in turn allowed opportunities for exploration of where one fits into one's lifeworld. In essence, by doing or participating in vocational activity, participants could then focus on culturally normal and appropriate experiences outside of mental illness. Engaging in job seeking and vocational-based endeavours allowed participants to function in valued life and societal roles. Speaking passionately about reasons she was looking for a job, Georgie said: "I don't want my mental illness to be an excuse for me anymore".

For Sonia, engaging in work brought about social validation:

> When we can get past that, through whatever it takes to get past that, and then to start having the people accept us, like normal people, and have that compassion and understanding of what we come from and what we've been through.

The worker role was meaningful and rewarding for participants. Besides missing the income and self-sufficiency that went along with paid employment, social aspects and the satisfaction of doing something well was articulated by all of the participants. Adam saw meaningful work as "validating of your own self". Georgie described a sense of identity and pride with work: "You feel a sense of achievement. A sense of somebody within yourself. A proudness. A confidence".

For the participants, engagement in ordinary and productive work was a way to a normal, good life. Marcus articulated this wish: "I hope to get some employment. I hope to, well, I would love to do the normal things, you know. Get a partner and that, holiday, I haven't been on holidays for a good ten years".

All vocational activities, including voluntary and part-time positions, as well as education and training, were deemed valuable in promoting social inclusion and connection to the community and society. Tim said that he was not interested in making his mental illness his life. "I'm much more interested in engaging with the community".

For Adam, being acknowledged as more than just a person with mental illness:

> Has been a huge thing throughout this journey. I now have a nine-to-five job. I can tell people like my neighbours or people I meet I work as a peer support worker. You can hear their mental cogs going over: "Peer means like you're like one of those, so you must have a mental illness, but you look ok to me, so I can accept you".

Besides belonging within what they saw as "normal" society, all participants aspired to contribute to help other people with mental illness and the wider

community. Tim felt strongly that: "I should be involved at some level in order to give something back". Nell expressed similar feelings: "I've always wanted to help people. I like helping people and being involved".

4.4 Discussion

The purpose of this phase of the research was to describe the experiences of people with mental illness in pursuing and achieving their vocational aspirations. The results indicated that although people with mental illness saw vocation as meaningful, and a way to re-establish their sense of identity and self-worth, they experienced a number of challenges in attaining their vocational aspirations.

People with mental illness are vulnerable and experience social devaluation and stigmatisation. The experience of mental illness can be wounding, as discussed by participants. Participants had experiences of rejection by some, if not all of the following: family, friends, employers, the community, and mental health service providers. According to Wolfensberger (2000), a consequence of being rejected is that the devalued person gets cast into roles that are devalued by society. This was true of participants in this phase of the study, where their access to valued roles were severely diminished, for example being a parent, or being a supervisor.

The results of this phase indicated that people with mental illness experienced a number of challenges as occupational beings, that is beings who participate in culturally and personally meaningful activities (Clark et al., 1991; College of Occupational Therapists, 2006; Kielhofner, 2002). Humans are occupational beings whose existence depends on the enablement of diverse opportunities and resources for participation in culturally-defined and health-building occupations. Beyond *vocation*, occupations are all the ways in which we occupy ourselves (Townsend et al., 2003). Occupational justice is premised upon the vision of an occupationally just society in which all people, regardless of disability, socio-cultural position, geographic location, age, or gender have

the opportunities, resources, privileges, and rights to engage in occupations they need or want to (Townsend & Whiteford, 2005). In an occupationally just environment, people with mental illness would have access to adequate supports and resources to participate in their chosen vocational activity. By applying the occupational justice framework to this phase of the study, it is clear that the participants experienced all four forms of occupational injustice. According to the participants in this phase, occupational deprivation, alienation, marginalisation, and imbalance were challenges they faced in vocational journeying.

When the participants were denied the opportunity and resources to participate in vocational activities, they experienced occupational deprivation. Occupational deprivation occurred through restrictions in employment opportunities, lack of person-centred support, and the absence of assistance in negotiating services. The injustice was predicated by the mental health system, which did not provide adequate funding to support people with mental illness' vocational recovery.

Occupational alienation describes a meaningless and purposeless everyday life experience (Townsend et al., 2003). It is believed to occur with subjective experiences of "isolation, powerlessness, frustration, loss of control and estrangement from society or self as a result of engagement in occupation that does not satisfy inner needs" (Wilcock, 2006, p. 343). When participants were required to participate in seeking employment that did not hold meaning for them, occupational alienation occurred. This point raised the importance of the person's vocational aspirations being central to the employment seeking process to foster meaning, recognition, and reward for the person.

Occupational marginalisation can occur when individuals lack the power to exercise occupational choice (Townsend & Whiteford, 2005). From this perspective, we can see that participants were stigmatized by mental illness and suffered occupational marginalisation in their experiences of being devalued, rejected, and isolated.

The majority of the participants were unemployed or underemployed, which was a form of occupational imbalance because they had too little to do to meaningfully occupy themselves. By contrast all participants saw that participation in vocational activities added to and fulfilled their lives in a meaningful and purposeful way.

The group of participants in this phase of the research spoke about the lack of support in their lives. They used terms such as neglect, isolation, and abandonment to describe their experiences. "As Foucault (1984) pointed out, many groups in western culture are 'maneuvered by myths' (p.8); one of the cruellest myths experienced by people with disabilities is that they do not have the same social needs as other citizens" (cited in Lord & Hutchison, 1993). Underlying occupational determinants influence what occupations are valued and rewarded, and who may participate in them (Townsend & Polatajko, 2007). People with mental illness are excluded from participating in valued occupations because they may be unseen, undervalued, or their abilities may be underestimated.

In this phase of the research, the term vocation was understood by participants as being broadly defined and encompassed education, volunteer work, and employment experiences. They believed vocation contributed to a person's self-concept and vocational aspirations. Achievements were seen as expressions of individual personality. The participants were clear that these activities were productive, meaningful, challenging, and rewarding. There was a focus on obtaining paid work because participants described *work values*, which were the desirable outcomes they wanted through work and the important components they felt would lead to work satisfaction (Elizur, 1984; Sagie, Elizur, & Koslowsky, 1996). The most widely used classification of work values organises them into four dimensions: intrinsic, social, extrinsic, and prestige (Elizur, 1984; Ros, Schwartz, & Surkiss, 1999). Intrinsic values cover the importance placed on autonomy and interest, or intangible rewards (Elizur, 1984; Ros et al., 1999). Participants in the study stressed the importance of being able to choose a vocation that held meaning to them

personally. Social values refer to the significance of working with people and contributing to society (Elizur, 1984; Ros et al., 1999). All participants described wanting to help other people with mental illness and the wider community. Extrinsic values refer to tangible outcomes such as making money, material possessions, and having job security (Elizur, 1984; Ros et al., 1999). Participants explained that they would be better able to meet living expenses and engage in valued life roles by participating in paid employment. Prestige values represent the importance placed on respected and prestigious work roles (Elizur, 1984; Ros et al., 1999). It was important for participants to belong to society and be recognised as a worker, not a welfare recipient.

Each participant had their own work values, but that the data showed patterns in terms of what appeared important to people with the lived experience of mental illness. A person's work values predict their career choice, and the fit between a person's work values and their work environment is significant in predicting job satisfaction and performance (Guastello, Rieke, Guastello, & Billings, 1992; Judge & Bretz, 1992; Knoop, 1994; Schulenberg, Vondracek, & Kim, 1993; Vodanovich, Weddle, & Piotrowski, 1997). This values-based understanding of vocation is reflected in the literature (Holland, 1996; Super, 1973) where aspirations are integrated with a person's purpose in life (Dik & Duffy, 2009; Hall & Chandler, 2005). According to participants, a central role of vocation was re-crafting one's authentic self through different experiences in their recovery journeys.

Work is an important component of vocation. In addition to income, work provides an arena for social interaction and development of identity (Jakobsen, 2001; Magnus, 2001). Work is considered an important key to social inclusion for people with mental illness (Grove, 1999). Participants identified socialising as an important reason for why they want to work. This fostered the development or redevelopment of valued social roles (Kennedy-Jones, Cooper, & Fossey, 2005). Senses of pride and achievement, as well as self-sufficiency were also consistently mentioned. One participant viewed the earnings from

paid work as a means of facilitating his role as a parent to his children, so that he could afford to spend money on care giving and leisure activities with them.

A theme reflected in each narrative was that person-centred support through the whole process of seeking employment was vitally important. Participants valued being accepted and understood by their employment consultants. The importance of supportive relationships between people with mental illness seeking employment and employment service providers is consistent with previous studies (Dunn et al., 2010; Henry & Lucca, 2004; Honey, 2004; Marwaha & Johnson, 2005), and fostering supportive personal relationships is an evidence-based aspect of recovery (Tew et al., 2012).

There are complex situations around employment and disclosure (Goldberg, Killeen, & O'Day, 2005). More than half the participants were interested, pursuing, or engaged in peer support work. This role allowed participants to contribute to helping other people with mental illness. Working as a peer support worker exempts participants from many painful and difficult decisions regarding disclosure of mental illness because it is explicit within the role. Peer support workers would not risk the same amount of stigma from their employers as their employers would be accepting and understanding of mental illness. Peer support is seen as a method to facilitate recovery (Coatsworth-Puspoky, Forchuk, & Ward-Griffin, 2006). Interestingly, providing peer support has been shown to be more beneficial than receiving it (Bracke, Christiaens, & Verhaeghe, 2008). Being able to provide support strengthens social competence and problem solving capacities, and brings about substantial personal benefits, such as a safe, sympathetic employment setting (Mowbray, Moxley, & Collins, 1998). This finding led me to reflect upon the peer support role in terms of whether it promotes normalisation through a vocational role, or if it retains the peer support worker firmly within the mental health system, or if it does both. This was a complex question that was outside of the scope of this research.

Participants who were successful in pursuing their vocational aspirations spoke in depth about their recovery journeys. As discussed in Chapter Two, although notions of vocation and recovery processes share similar metaphors, such as journeys, vocational recovery has been defined as the process through which people with mental illness regain their worker role and reintegrate into the workforce (Dunn et al., 2010). This definition does not encompass broader understandings that accompany either concept. The results from this phase of the study show that vocation holds deep meaning for people with mental illness, however, vocational services accessed by participants focussed solely on training and employment. From this phase of the study, and associated reviews of the literature, it was clear that the principles and practices associated with vocational recovery had yet to be explored. This exploration now forms a significant part of the thesis and will be explored in the next chapter.

4.5 Conclusion

Vocation is a rich, broad concept that people aspire towards, and yet discovering vocation for oneself is an enigmatic process as there is no fixed formula to support people in finding their true métier in life. Although personal recovery was a subtheme that emerged from the focus groups as a background concept, when I had completed the analyses of the in-depth interviews it had become a central consideration and informed the remainder of my research. The process of recovery allows people with mental illness to know themselves and their world. It is a dynamic way for people to interact with their environment, whilst discerning their vocation. In conclusion, the process of vocational recovery may be vital in shaping the path to attainment of one's vocational aspirations. Embedding the concept of vocation into individuals' recovery journeys may have theoretical and practical benefits, in terms of understanding how best to support people with mental illness in discerning, achieving, and maintaining their vocational aspirations. The next chapter details the development of a definition of vocational recovery and a

framework that describes the facilitators of vocational recovery in mental illness.

Chapter 5: Generating a Framework for Facilitating Vocational Recovery

5.1 Introduction

In the chapters to this point I have drawn attention to the growing emphasis and importance given to recovery within mental health service provision (Slade, 2009). Although recovery has been progressively supported by policy makers (Mental Health Commission, 2010), *vocational recovery* is yet to be clearly defined.

The term *vocational recovery* has been used in the literature; mainly to describe the process through which people with mental illness return to the competitive workforce (Dunn et al., 2010; Russinova et al., 2002). However, as discussed in the previous chapter, the term *vocation* is generally used interchangeably with *work* and *employment* which tends to detract from its otherwise rich meaning. In a thorough literature search, I could not find any description of *vocational recovery* that could reflect adequately the contemporary understandings of recovery, or the needs and aspirations reported by the people with mental illness who were participants in Phase One of this research. In Phase Two of the study, reported in the chapter that follows, a Delphi study was used to describe key stakeholders' understandings of vocational recovery in mental illness. An ecological approach was applied to these descriptions, and a Vocational Recovery in Mental Illness Model and a Framework for Facilitators of Vocational Recovery in Mental Illness were developed.

5.2 Research Methodology

5.2.1 Delphi Study

The Delphi methodology is a well-established and systematic way of collecting, organising, reviewing, and revising the opinions of panels of individuals (Geist, 2010). The means of determining the extent to which consensus exists amongst a group of people typically has three features: anonymity, controlled feedback, and statistical group response (Jones & Hunter, 1995). It involves the presentation of a questionnaire or interview schedule to a panel of informed participants or experts in a particular field, in order to obtain their opinion or judgement on a specific subject (McKenna, 1994). Subsequent to receiving responses, the data are summarised and a new questionnaire is returned to each participant for comment and further responses (McKenna, 1994). This approach resembles a highly organised meeting of experts that is controlled by a chairperson who is adept at summing up responses by reflecting participants' views back to themselves, so that they can proceed to further develop these responses (Hitch & Murgatroyd, 1983). The iterative process of the Delphi study is anonymous between participants, allows for equal weighting of participants' views, and renders the process of determining priorities transparent. The main advantage of the Delphi technique is reported to be the achievement of consensus in a given area of uncertainty or lack of empirical evidence (Dawson & Barker, 1995). This is important in describing vocational recovery because of the paucity of theoretical and practical clarity of this concept. The feedback between rounds can broaden knowledge and stimulate new ideas.

There is a wide variation in panel sizes of Delphi studies ranging from 10 to 1685 (Reid, 1988). According to Adler and Ziglio (1996), good results can be obtained with small panels of 10-15 participants in a homogenous group of experts. As there are no universally agreed criteria for selection of panellists, and no information regarding ideal numbers of panellists (Keeney, McKenna, & Hasson, 2011), common sense and practical logistics guided the process in

my study. Having expertise, informed opinions, or life experience are generally important requirements in selecting Delphi panel members.

The Delphi technique was selected in order to define vocational recovery and develop a Framework for Facilitators of Vocational Recovery in Mental Illness as, has been illustrated in Chapter Two, there is a paucity of literature and theoretical development associated with the concept. The framework is intended to define vocational recovery and its facilitators in mental illness in ideological and practical terms. This method allowed panellists to build on their views about vocation and recovery, and then jointly create a description of vocational recovery and how that can be shaped by a diverse group of stakeholders, being people with mental illness, mental health service providers, and policy makers.

5.3 Method

In this section, I describe how I implemented the Delphi study in order to develop a Framework for Facilitators of Vocational Recovery in Mental Illness. The Delphi study was conducted in the second phase of the research. The first round questionnaire was developed from the themes and subthemes that emerged in Phase One regarding vocational recovery. The questions in the first round of the Delphi study were intended to explore broad understandings of vocation and recovery, as well as describe what vocational recovery involves for people with mental illness, service providers, and policy makers.

5.3.1 Panel selection

Participants selected for this Delphi study were key stakeholders in the area of mental health; including mental health service users, mental health professionals, families, advocates, carers, researchers, employers, and policy makers. These multiple data sources were used to improve the validity of the results (Grbich, 1999) and reduce bias (Jones & Hunter, 1995).

Convenience sampling was utilised in the recruitment of panellists. Industry partners and contacts from organisations such as Fremantle Hospital, Rockingham Health Service, Ruah Workright, Richmond Fellowship, and the Western Australian Mental Health Commission, were approached. Academics at Curtin University with experience in mental health service provision were also approached. Following this first round of contacts, nominations for additional panellists were sought from those who I had already secured as panellists.

Twenty-eight individuals were approached about the study, and twenty-one panellists participated in the first round of the study. Three employment consultants, two clinicians, one academic, and one consumer who were approached did not participate in the Delphi study. From these, four cited having no time as a reason, and the other three did not respond to follow-up attempts.

5.3.2 Demographic profile of panellists

Of the Delphi panellists, 19% (n = 4) were male and 81% (n = 17) were female. This high percentage of females in the panel was representative of the mostly female healthcare workforce. The main healthcare professionals who were panellists were occupational therapists, social workers, and clinical psychologists. In a 2006 survey of the Australian health and community services labour force, these professions were made up of 93.2%, 82.8%, and 75.4% females respectively (Australian Institute of Health and Welfare, 2009). Ten panellists identified themselves as being members of one stakeholder group, ten identified themselves as being part of two groups, with the remaining panellist identifying herself as being part of three groups. For example, a panellist may be both an academic and a mental health professional, or a panellist may be a peer support worker thereby being both a user of a service and a professional. The representative percentages of each stakeholder group are presented in Table 5.1.

Table 5.1: Stakeholder groups

Stakeholder groups	Number of Delphi panellists who identified themselves as being part of this group
Mental health service user	10
Mental health professional	13
Family member, advocate and/or carer of a mental health service user	3
Academic	5
Employer of a mental health service user	1
Policy maker	1

5.3.3 Data collection

A three-round Delphi study was conducted. The first round of questions was developed from the findings of Phase Two of the study in order to explore the concept of vocational recovery.

The first round of Delphi questionnaires was administered using face-to-face interviews or a web-based survey tool (wufoo), and it was up to each panellist to select the method of data collection they preferred (see Table 5.2 for details). This was important because some panellists preferred personal contact and answering the questions verbally, whereas other panellists found the web-based questionnaire more convenient to work with. Both versions of the first questionnaire were identical in content and design, and written consent was obtained from all panellists. Where panellists chose to have interviews, I met with them individually at locations and times that were convenient to them, and audio recorded each interview. The interviews were professionally transcribed verbatim.

Following analysis of the results of the first questionnaire, the responses were organised and restructured, as I have detailed in chapter three. This was returned to panellists through email or in face-to-face interviews for comment and clarification in the second round. All comments were incorporated into the responses, and the third and final round involved emailing participants the finalised questions and answers.

Table 5.2: Breakdown of data gathering methods according to how panellists identified themselves

	Online	Interview
1	mental health service user & mental health professional	mental health service user, advocate & mental health professional
2	mental health service user	mental health service user, mental health professional & academic
3	mental health professional & academic	mental health service user
4	mental health professional & academic	mental health service user & mental health professional
5	mental health professional & academic	mental health service user
6	policy maker	
7	mental health service user & mental health professional	
8	mental health professional & academic	
9	mental health professional & family member of a mental health service user	
10	mental health professional	
11	mental health professional	
12	mental health service user	
13	mental health service user	
14	carer of a mental health service user & employer of mental health service users	

15	mental health professional	
16	mental health professional	

5.3.3.1 Round One

Panellists were asked to comment on meanings of vocational recovery and offer other descriptions of the concept by answering six questions. Further to this, panellists were asked which stakeholder group they were a member of. The questions asked are presented in Table 5.3.

Table 5.3: Round One Survey Questions

1. What does 'vocation' mean to you a) personally and b) as a concept that may be relevant to people with mental health issues?
2. In describing recovery for people with mental health issues, what do you see as the five most important factors?
3. What additional factors must be considered in defining 'vocational' recovery, as opposed to ideas of recovery?
4. What are some challenges to vocational recovery for people with mental health issues?
5. What activities promote vocational recovery for people with mental health issues?
6. How can services encourage vocational recovery for people with mental health issues?

5.3.3.2 Data Analysis of Round One

A research team comprising five academics (which included myself) within the Faculty of Health Sciences at Curtin University analysed the data for the first round of the survey. The research team members had backgrounds in occupational therapy, social work, clinical psychology, and anthropology. Research team members carried out a qualitative analysis of the interview transcripts and online written responses in order to identify and describe the key themes or issues expressed by participants. The transcripts were divided

into two lots, with four of the five team members participating in each of the two group data analysis sessions. Not all five team members could participate both data analysis sessions because they had other commitments. The process used was as follows:

1. Each of the responses (interview transcripts or online written responses) was read individually by four research team members. Research team members marked verbatim statements that held meaning, added comments, and separated the free text into themes for each of the six questions that were asked. Researchers wrote each theme onto a small card with verbatim words or statements that reflected the theme.

2. Researchers then met and used a card sort process to group the themes into broader, overarching themes that were seen to be related and coherent for each question. Comments and descriptions from all panellists were condensed into themes and subthemes using this card sort method.
3. I organised each set of cards by matching their related questions to the themes and subthemes within that particular question.

4. At the second meeting, this same process was repeated for the remainder of the responses, with themes and subthemes added to the stack of cards for each question.

This process facilitated deep discussion and clarity around the answers given by the panellists. The outcome from this process was six sets of key themes, each set corresponding to one question, and each theme comprising component subthemes.

Subsequent to this, the cards relating to each question were collated and duplicates were removed. Where possible, the terminology that had been used was unified. From the list of themes and attributes, I developed the first draft of the responses to the survey. This document was discussed with my PhD

supervisors and revised three times, with the aim of presenting the responses in concise and easily understood language.

5.3.3.3 Round Two

The document containing consolidated themes and attributes were sent to the panellists for validation in the form of the responses to the survey questions via email and in face-to-face interviews. Panellists were asked to review the collated answers and provide feedback for each question. Participants selected the items they considered to be essential in answering each of the six questions describing vocational recovery, or object to items they disagreed with. They were also invited to give reasons for their decisions and opinions.

5.3.3.4 Data Analysis of Round Two

I reviewed the responses from each panellist and modified the responses to the survey according to the feedback given. There are no firm rules for establishing when consensus is reached, although the final round will usually show convergence of opinion (Linstone, Turoff, & Helmer, 1975). Through discussions with my PhD supervisors, it was decided that consensus had been reached in five out of the six questions. The remaining question had vastly polarised answers. As response exhaustion had occurred after two rounds, especially with busy stakeholders, the decision was made that I would refine and finalise the responses from the document into the framework.

5.3.3.5 Round Three

The summary report with the finalised responses was sent to all panellists, and they were given a two-week period to respond with any feedback. All remaining panellists agreed with the finalised responses. Subsequent to this, I briefly interviewed by telephone two panellists who had broad ranging understandings of recovery that reflected both the literature and stakeholder views. I did this in order to gain feedback on the findings, particularly in relation to the applicability and credibility of the results.

5.4 Results

The qualitative responses from round one and two of the Delphi study are presented below. As this was a descriptive open-ended survey without ranking or scales, statistical analysis was not performed.

5.4.1 Round One

The first round of the Delphi study yielded a return of 100%. The responses were rich in meaning in both transcribed interviews and online surveys. There were similarities in most responses, except in the question regarding recovery.

What does 'vocation' mean to you a) personally and b) as a concept that may be relevant to people with mental health issues?

In describing vocation, panellists referred to earning money, employment, work, education, and volunteering, however this definition was subsumed under broader and deeper philosophical understandings by all panellists. Over three quarters of the meaning units that were identified by the research team in data analysis were concerned with vocation as a *calling* and an existential expression of oneself. These broader notions referred to the engagement in purposeful, meaningful, and productive activity, where the activity is what a person feels they are meant to do. The activity allows a person to be authentic or true to their own personality, spirit, or character. It was more than a job or career.

Panellists also reported that they believed vocation to be an activity based on choice that brings about personal benefits. There were a considerable range of benefits described: financial rewards; fulfilment from achieving work goals and career development; adoption of meaningful roles, such as being a team member and a workmate; personal growth and development, including

improved self-esteem, confidence, a sense of purpose, an ability to meet challenges, and creative expression; relationships with other people; stability in one's life; and satisfaction from contributing to society.

From these answers, the research team decided to modify the question for a following distribution of the questionnaire to: "How may vocation be described"?

In describing recovery for people with mental health issues, what do you see as the five most important factors?

This question elicited the most varied responses in this round. I was somewhat surprised by the variation in answers to this question, given the expertise and experience of the panellists, and the amount of literature and growing evidence about recovery. Panellists who were clinicians and early career academics with recent experiences of being clinicians communicated their understandings of *clinical* recovery and symptom management in detail, and only touched lightly on *personal* recovery, mainly by quoting well-referenced definitions. Interestingly, two panellists who were in psychosocial rehabilitation programs at the time of the survey also spoke about insight into mental illness and symptom management. These definitions of recovery were synopsised as: an acceptance of mental illness and oneself; and an ability to self-manage, including getting plenty of rest, anticipating likely problems, doing regular exercise, being compliant to a medical regime, monitoring illness, having strategies in dealing with fears of past experiences, and active coping.

All other panellists explained recovery in terms of engagement in meaningful occupations based on interests and preferences and having balance in work, rest, and play. Panellists who identified themselves in more than one role (e.g., mental health service users and professionals) were clear in expressing recovery in terms of hope and optimism for the future and a good life.

Factors that supported recovery were described. These were divided into personal and external factors. Personal capacities and beliefs that allowed a person to set personal goals and engage in activities included: self-belief and a sense of purpose; empowerment and motivation to change; confidence in one's own identity; self-determination; and being contented. Another important aspect was a familial, peer, and social support network that fostered personal contact and community inclusiveness; and is available, accessible, appropriate, inclusive, and flexible. Health professionals who supported access to early intervention, provided effective diagnoses and clinical intervention, and assisted in developing strategies to overcome barriers to recovery were also acknowledged. Structural resources that supported personal capacities, such as: stable accommodation and having basic needs met (food, shelter, and warmth); routine and structure to life; and an income were seen as advantageous in recovery journeys.

This question was shortened to: "How is recovery described for people with mental illness?" in the second round.

What additional factors must be considered in defining "vocational" recovery, as opposed to ideas of recovery?

In answering this question, all panellists named facilitators of vocational recovery, and many discussed aspects of recovery in general. In terms of separating the concepts of vocation and recovery, only four panellists identified systematic support in vocation and value of vocation in providing meaning and motivation in recovery. As such, the research team decided to create a question on facilitators of vocational recovery to match the answers. This is presented in the next section.

Upon reflection, I could have worded the question more specifically in order to obtain a shared understanding of vocational recovery. However, the panellists had provided in-depth responses about both of the constituent concepts, and

these could be combined in expressing a definition that was consistent with the literature. These responses specified that vocation was a way for a person to focus on an aspiration that held deep meaning and purpose that could be worked on in a demonstrable way.

What are the facilitators of vocational recovery?

Facilitators of vocational recovery included providing support for people with mental illness from peers and service providers. This is because paid work allows individuals to have money for basic things and financial stability. This independence was seen as motivating for people who had not been part of the workforce for periods of time. The facilitators that services could incorporate included: an acknowledgement of each individual's capacity and choice, so that individuals may participate in their chosen area of interest; and support for education and skill development, early on-the-job training, and access to information about vocational recovery. Panellists also described supportive vocational environments that recognise mental illness as an illness, free from stigma. They explained that this was a way for people to make a contribution and be a citizen, which allows an individual to be part of a team and participate and be included in society.

What are some challenges to vocational recovery for people with mental health issues?

The challenges people faced were defined in individual, social, and systemic areas. These challenges were described by panellists who had lived experience of mental illness as major barriers to accessing services, such as DES (formally DENs), to assist in vocational recovery. The challenges that were strongly voiced by all panellists were stigma and lack of opportunities. Individuals faced personal challenges with regards to symptom management and side effects from medication, adjustment to changes in medication, and genuine

limitations on performance due to symptoms. In addition to this, dealing with mental health issues such as social anxiety, fear of change, apprehension about relapse, and lack of motivation compounded the difficulties of returning to the workforce. People experienced disempowerment, loss of hope, loss of confidence, and loss of identity and purpose with mental illness, and gaps in their employment history. Lacking current skills, qualifications, or recent experience, made negotiating the employment arena challenging.

Social and interpersonal challenges to vocational recovery included stigma, discrimination, and prejudice, which influenced an individual's decision to disclose. Low expectations from service providers, the community, and employers were demotivating elements that promoted the sick role, and restricted social networks limited vocational opportunities. People experienced a lack of mentoring and support, as well as difficulties negotiating flexible work arrangements with prospective employers and workplaces.

The mental health system, policies, and service provision also posed challenges, such as limitations in the current employment policy regarding open employment, rates of pay, and funding to vocational programs. Besides this, panellists spoke about a lack of mutual obligation – the principle that it is fair and reasonable that people on benefits take responsibility and do their best to find work as personal growth comes from this arrangement. The disability support pension arrangements provided financial disincentives to work. Reduced flexibility in vocational opportunities and service response to people's changing needs was seen as a difficulty for many people re-entering the workforce, and related to the tensions around disclosure. Besides these, panellists listed employment assessments not being based on personal strengths, inconsistent clinical support, and expensive training programs as challenges.

This question was shortened to "What challenges to vocational recovery do people face"?

What activities promote vocational recovery for people with mental health issues?

Panellists described personal, service-based, and government-based activities that promote vocational recovery. Close personalised support and mentoring were mentioned most often, as well as dedicated mental health DES providers. Personal activities that involved staying connected and being engaged in life were seen as important. These included keeping well by eating good food, having a routine, exercising and being active, and being able to self-manage mental illness. Having balance in life by engaging in meaningful work and leisure activities was also deemed important. Vocational recovery was supported by learning life skills such as time and money management, taking transportation, communication skills, and building confidence and self-esteem. Finally, being committed to short-, medium-, and long-term personal goals; and participation in social activities that promoted relationships with peers was a way that people with mental illness could invest in their own vocational recovery. Many of these personal activities were described by panellists who were mental health service users also working as mental health professionals. Panellists without lived experience of mental illness only spoke of service-, and government-based activities.

Service-based activities included person-centred programs that focus on training, education, work experience, and supported employment. Panellists used recovery-based terminology such as "creating a space to grow", and explained that it involved engagement by people delivering services, early identification of vocational goals, small steps in training, and a gradual return-to-work. Early intervention programs with strategies for long term self-management of illness, team support from a range of professionals including psychiatrists, psychologists, occupational therapists, vocational advisors, and peer support workers were also identified as important for vocational recovery. The main service-based activity that promoted vocational recovery was having access to specialised DES that worked in close partnership with clinical services.

Government policy-based strategies included providing stronger incentives to work, and better support for education or training providers.

How can services encourage vocational recovery for people with mental health issues?

The most frequent responses to this question involved descriptions of the values of person-centeredness. Service providers could encourage vocational recovery by being attentive, responsive, flexible, encouraging, and understanding in providing individualised support. By acknowledging individuals' existing skills and history, and focussing on their capacities, abilities, and potential, service providers would use a strengths-based approach to supporting people with mental illness. Acknowledging individuals as experts in their own recovery and empowering individuals to make informed decisions and take responsibility for them was a means of fostering ownership of the process. Finally, creating opportunities with vocation as a central goal of recovery and providing evidence of successful role models helped people with mental illness to focus their efforts and be positive about the future.

Panellists felt that influencing employers and the community by raising awareness and engagement, and advocating for people with mental health issues were roles that service providers could perform better. There was a firm emphasis on facilitating strong partnerships, such as including DES within the mental health teams and building relationships between service providers and employers. Finally, remaining open to new and novel forms of employment or volunteering was discussed as being innovative in creating opportunities for people with mental illness.

5.4.2 Round Two

The responses from the first round were given to panellists through their chosen method, either by email, or through a face-to-face interview (see Appendix D for the Round Two Questionnaire). Round Two generated greater clarity in terms of language used in describing recovery. There was general consensus in all questions, except descriptions of recovery. These are detailed in the section below.

The response rate in second round of the Delphi study was 81% (N = 17). Two panellists could not be contacted as their email addresses had changed, one panellist cited being time-poor as a prohibitive factor to continued participation, and the final panellist did not respond to two reminder emails. All the panellists who responded to this round did so by email, except for two panellists who preferred face-to-face interviews. Panellists were asked to review the collated answers and provide feedback on each question by indicating if they agreed or disagreed, reasons for their responses, and further clarification if appropriate. There was general agreement in terms of the responses to all the questions, except for the question about how recovery is described for people with mental illness. The main findings from each question are described below:

How may vocation be described?

All panellists agreed with the description of vocation as a calling, with seven panellists indicating strong agreement with this description. One panellist wrote: "This is a very good statement about vocation", and another stated: "I think the first definition of vocation captures the essence more accurately as it explains why it is different than a 'job' or 'career', whereas the second description sounds like what a job can provide". This second description listed the personal benefits that vocation may provide. All respondents agreed with this list, with one panellist adding: "I think there's another component to this, broader than 'meaningful contribution' and 'being a team member' where

vocation lends you the identity of a trade, profession, etc… regardless of employment status. It's a common identity we adopt, and society readily perceives it".

How is recovery described for people with mental illness?

There was agreement between all panellists that a broad definition of recovery was hope and optimism for the future and a good life. Eight panellists strongly disagreed with the "prescriptive definitions of what is involved in recovery, particularly the statement of 'compliance with a medical regime'". They were critical of the clinical, negative, and narrow language used, such as "insight" and "maintain wellbeing", the "medical model" focus, and the lack of acknowledgement that "recovery is a very personal journey that should be both described and directed by the person on that journey". Two panellists offered cited definitions of recovery as preferred definitions, which were included in the definitional aspect of the framework. With regards to the language used in the question, one panellist pointed out that: "Recovery should not be described *for* people with mental illness, I feel recovery should be described *by* people with mental illness". In consultation with my supervisors, I amended the question so it was more recovery-focussed. It was changed from "In describing recovery for people with mental health issues, what do you see as the five most important factors?" to "How is recovery in mental illness understood?"

With regards to personal and external factors in recovery, all participants agreed with the content of the lists.

What are the facilitators of vocational recovery?

There was agreement from all panellists about the facilitators of vocational recovery. One panellist pointed out that "the notion of recognition (of mental illness as an illness) presumes that this is a defined and settled explanation,

rather than heavily contested terrain". In view of these comments, the answer was modified from "Supportive vocational environments that recognise mental illness as an illness" to "Supportive vocational environments that recognise mental illness as an illness, free from stigma" in order to clarify its meaning.

What challenges to vocational recovery do people face?

Besides comments on the language used, there was agreement from all panellists about the challenges people face. One participant explained that "recovery understandings are clear that recovery is not a linear journey – the out-dated concept of relapse is argued to position recovery as linear due to the suggestion that one regresses or relapses back. Rather, we see it much differently". This feedback on language was incorporated into the document and the language used was modified to ensure it fit the nuances of recovery. This can be found in Appendix E.

What activities promote vocational recovery for people with mental health issues?

As with the other questions, feedback was given that some of the language used was clinical and non-recovery focussed. The answers were expanded to be more descriptive and less illness focussed. Besides this, there was agreement regarding the content of answers. Appendix E has details of this.

How can services encourage vocational recovery for people with mental health issues?

There was strong agreement by all panellists about the answers to this question. Two panellists with lived experience of mental illness commented that "acknowledging individuals as experts in their own recovery" would prove problematic if the individual did not have an understanding of "where they

were at". They suggested phrasing this point differently, without the word "expert". The term expert was used by the majority of the panellists to acknowledge the person in recovery as central to their own recovery. As such, I took their advice and re-phrased the sentence accordingly. This can be found in appendix E.

5.4.3 Final responses to questions

The final document that was prepared for panellists incorporated the responses from round two of the Delphi study (see Appendix F). In consultation with my PhD supervisors, I removed a small number of outlying responses, as well as draft responses that were seen as unacceptable by the majority of the participants. These responses were overly medical and did not fit with the current understandings of recovery. I made changes in terminology where feedback from participants was given. However, I included different contested ideas in the document as a point of discussion. Although some views may not be shared by all, different responses from the stakeholders involved in this survey reflect the varied ideas that exist in the Western Australian mental health system. Only including responses where there was total agreement would limit the complexity of the topic and diminish the variability of responses to a dynamic issue. As such, all responses from round two were noted and sent to all the panellists for final comment. All the panellists from round two were sent a copy of the document and asked for comment and 100% agreed with the content of the document, and no further changes were made.

From these rich responses to the questions, I condensed the major elements that were exclusively describing vocational recovery as a whole concept. My PhD supervisors were closely consulted in this narrowing down process. The following section presents a definition of vocational recovery, an ecological approach to vocational recovery in mental illness, and a Framework for Facilitating Vocational Recovery in Mental Illness. The barriers to vocational recovery are also presented.

5.4.4 A definition of vocational recovery in mental illness

Vocational recovery involves regaining or establishing a range of valued roles associated with vocation as broadly defined: as a calling, where a person chooses to engage in purposeful, meaningful, enjoyable, and productive activity; feels that the activity is what they are meant to do; and allows them to be authentic or true to their own personality, spirit, or character.

Vocational recovery is complex and holds rich and personal meanings for individuals. There may be different meanings attributed by service providers who may be accountable for outcome measures and may be constrained by the policy and environmental contexts.

5.4.5 An Ecological Approach Applied to Vocational Recovery in Mental Illness

An ecological systems approach (Bronfenbrenner, 1977) is useful in organising and interpreting the phenomenon of vocational recovery in mental illness as described by Delphi study panellists because it directs attention to both individual and environmental determinants. Figure 5.1 illustrates an ecological systems approach to vocational recovery in the different spheres of a person's life.

Figure 5.1: Vocational Recovery in Mental Illness Model (based on Bronfenbrenner, 1977)

In describing vocational recovery, the person with mental illness is in the centre of the model, and their personal understanding of vocational recovery shapes their journey through interactions with services and society. A person's unique life shapes their attitudes, values, feelings, goals, skills, and roles, and

vice versa. It is by the process of engaging in vocational activities and interactions that the person comes to make sense of their world and understand their place within it. Ideally, a person should have the opportunity to explore their vocational aspirations. Employment or paid work may be part of a person's vocational recovery journey, which affords the person money for basic things and financial stability. Within structural and societal contexts, people negotiate complex constraints of mental illness and choose to engage with services for personal and vocational support, as well as familial, peer, and social networks. In doing so, they discover (or rediscover) their vocational recovery aspirations and goals. Staying connected and being engaged in life are central in promoting vocational recovery. Dedicated mental health employment consultants who are person-centred in their approach are in ideal positions to facilitate positive vocational experiences for people with mental illness. Service providers are able to connect and develop positive relationships with people with mental illness.

Systemic challenges to vocational recovery exist regarding open employment, rates of pay, transitional vocational preparation, and funding of vocational programs. Besides addressing these challenges, government policy-based strategies that promote vocational recovery for people with mental health issues include providing stronger incentives to work and support for education or training providers.

At a macrosystem level, societal attitudes and ideologies of the culture determine if challenges such as stigma, prejudice, and discrimination taint a person's experience of vocational recovery. Over time, sociocultural conditions have gradually changed to be more inclusive and supportive of people with mental illness.

Table 5.4 presents the key findings of this phase in terms of the facilitators to vocational recovery within each ecological level, and across levels as appropriate. In analysing the responses from the Delphi panellists, many of the

elements that affected vocational recovery were person-centred or service-oriented; however, panellists also identified policy and societal factors.

Table 5.4: A Framework for Facilitating Recovery in Mental Illness

Ecological level	Facilitators that affect a person's vocational recovery
Individual level: Person with mental illness	▪ Keeping well by eating healthily, having a routine, exercising, and being active; ▪ Having balance in life by engaging in meaningful work and leisure activities; ▪ Recognition of symptoms and side effects from medication, and planning for adjustment to changes in medication; ▪ Learning specific life skills to support vocation such as: time and money management, taking transportation, communication skills, and building confidence and self-esteem; ▪ Working towards managing mental health issues specific to returning to the workforce such as social anxiety, fear of change, and lack of motivation; ▪ Being committed to short-, medium-, and long-term personal goals; ▪ Participation in community-based social activities that promote relationships with peers; and ▪ Making a contribution and being a valued member of society.
Mesosystem, incorporating the interactions between Microsystem components:	▪ Person-centred programs that focus on training, education, work experience, and supported employment, namely IPS. Creating a space to grow involves engagement by people delivering services, early identification of vocational goals; ▪ Access to specialised DES that work in close

Vocational and mental health services	partnership with clinical services to provide programs for skill development and rapid job search; ▪ Early intervention programs with strategies for long term self-management of illness, team support from a range of professionals including psychiatrists, psychologists, occupational therapists, vocational advisors, and peer support workers; ▪ Transitional services that focus on training and guidance that will contribute directly to a person's ability to obtain employment and establish and maintain independence; and ▪ Service provider attributes: o Being attentive, responsive, flexible, encouraging, and understanding in providing individualised support; o Acknowledging individuals' existing skills and history, and focussing on their strengths, capacities, abilities, and potential; o Recognizing individuals as having knowledge of their own recovery from direct experience; o Supporting individuals to make informed decisions and take responsibility for them; o Creating opportunities with vocation as a central goal of recovery; o Providing evidence of successful role models; o Influencing employers and the community by raising awareness and improving engagement, and advocating for people with mental health issues, as well as supporting them in advocating for themselves in order to foster more consumer driven and operated services;

	○ Facilitating strong partnerships, such as including DES, vocational rehabilitation services, and housing services within the mental health teams and building relationships between service providers and employers; and ○ Remaining open to new and novel forms of employment or volunteering.
Employers	▪ Supportive and inclusive vocational environments, which are free from stigma; ▪ Flexibility of prospective employers and workplaces; and ▪ Mentoring and support.
Family and peers	▪ A familial, peer, and social support network that fosters personal contact and community inclusiveness and is available, accessible, appropriate, inclusive, and flexible; ▪ Good understanding of mental illness by friends, and family; and ▪ Social networks that provide vocational opportunities.
Exosystem: Policy context, that shapes welfare and disability services	▪ Providing stronger incentives to work, such as financial incentives to work that supplement the disability support pension. ▪ Support for education or training providers; ▪ Sustainable and supportive employment policy regarding open employment, rates of pay, and funding provided for vocational programs; ▪ Mutual obligations between stakeholders – growth

	comes from challenges and responsibility; and ▪
Macrosystem: Environment, society, mass media, and public	▪ Good understanding of mental illness by society; and ▪ Free from stigma, discrimination, prejudice, and narrow framings of mental illness.

Table 5.5 presents the barriers of vocational recovery in mental illness that were identified by Delphi Panellists. Although some of these barriers posed challenges to people with mental illness on a personal level, systemic and service barriers were far greater obstacles to vocational recovery. One factor, stigma, was a construct that was present across all levels in the ecological system.

Table 5.5: Barriers of vocational recovery in mental illness

Ecological level	Barriers that affect a person's vocational recovery
Individual level: Person with mental illness	▪ Symptoms, side effects from medication, adjustment to changes in medication, and genuine limitations on performance due to reactions and experiences; ▪ Dealing with mental health issues specific to returning to the workforce such as social anxiety, fear of change, and lack of motivation; ▪ Social devaluation and wounding leading to disempowerment, loss of hope, loss of confidence, loss of identity and purpose, self-stigma, and low expectations; and ▪ Gaps in employment history and lack of current skills, qualifications, or recent experience.
Mesosystem, incorporating	▪ A lack of collaboration between vocational and clinical mental health services;

the Microsystem: Vocational and mental health services	▪ Employment assessments not based on personal strengths; ▪ Inconsistent clinical support; ▪ A lack of access to personal recovery focussed education; ▪ Expensive training programs; ▪ Low expectations from service providers are demotivating elements that promote the sick role ▪ Reduced flexibility in vocational opportunities and service response to changing needs (e.g. periodic nature of illness); and ▪ A lack of transitional vocational preparation programs that focus on work skills that may have been lost or fractured through long-term unemployment.
Employers	▪ A lack of flexibility of prospective employers and workplaces; and ▪ A lack of mentoring and support.
Family and peers	▪ Poor understanding of mental illness friends, and family; and ▪ Restricted social networks may limit vocational opportunities.
Exosystem: Policy context, that shapes welfare and disability services	▪ Limitations in the current employment policy regarding open employment, rates of pay, and funding provided for vocational programs; ▪ A lack of mutual obligation – growth comes from challenges and responsibility; and ▪ Financial disincentives to work due to the disability support pension.

Macrosystem: Environment, society, mass media, and public	▪ Poor understanding of mental illness by society; and ▪ Oppression due to stigma, discrimination, prejudice, and narrow framings of mental illness that influence an individual's decision to disclose.

The Framework for Facilitating Vocational Recovery in Mental Illness was modified into a format that included a definition of vocational recovery. This framework will be presented to key stakeholders at the end of this research (Appendix H).

5.5 Discussion

The objectives of this stage of the study was to define vocational recovery and develop a Framework for Facilitating Vocational Recovery in Mental Illness based upon agreement from a broad range of stakeholders who have some kind of investment in the health and well-being of people with mental illness. In order to operationalise this objective I used a Delphi methodology. The Delphi study may best be viewed as a useful communication tool to generate debate, rather than reach a conclusion (McKenna, 1994). Nevertheless, I have confidence that it helped me reach the objective. There was some level of disagreement evident in the first phase of the study, specifically in the question about describing recovery. However, the panel reached general agreement in the second round of the Delphi study for most questions.

Certainly, the most feedback was given about language used in the first draft of the document that may not be conducive to recovery. Particular terms were viewed as generalising and labelling, such as "compliant" and "management of symptoms".

> Words have power. They have the power to hurt or soothe, to honor or insult, to inform or misinform. Words reflect and shape prevailing attitudes, attitudes that in turn shape social behaviour. Words both mirror and influence the ways we treat people and the ways they view themselves. And words – disparaging and disrespectful labels in particular – inflict emotional pain on those to whom they are applied (Wahl, 1995, p. 14).

The panellists who were most outspoken about using language that promoted acceptance, respect, and uniqueness were also very much advocates for recovery, whereas other panellists tended to "go with the flow" and agreed with recovery statements in the first iteration of the document that were not recovery-focussed according to recovery advocates. The differing opinions about recovery were indicative of the current climate of change in service provision in Western Australia. "Despite these many and varied initiatives

taking place across the states and territories and the national policy emphasis on recovery, this orientation has not been widely adopted and implemented" (Rickwood, 2004, p. 2). This was despite an acceptance by service providers of recovery principles as fundamental to the delivery of mental health care. Growing awareness of the limits of the established paradigm results in "a period of pronounced professional insecurity" (Kuhn, 1962, p. 67). According to Liberman and Kopelowicz (2005), recovery discourse can be expected to stimulate a backlash from professional groups whose power is threatened. It is also common for mainstream services to adopt recovery as a growing trend, and appropriate the label of "recovery" within rehabilitation services without meaningfully changing their function. These are all normal responses when existing paradigms are challenged (Kuhn, 1962). The responses given by clinical service providers and academics who had worked as clinicians may be reflective of the Western Australian context, where there may still be mixed adoption of recovery principles within service provision and fragmentation of services. This finding is explored in greater detail in Chapter Six.

The most widely-cited definition of recovery is from Anthony:

> A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993, p. 159).

In answer to the question on describing recovery, many participants listed factors or elements that led to recovery. In contrast, the participants who were recovery advocates were clear in articulating the principles of recovery, and gave rich descriptions of how recovery was understood.

It was pointed out that language used in the question on recovery did not fit in the recovery paradigm, which led me to question if recovery *from* or *in* mental illness was more appropriate. Although I amended the question to: "How is

recovery from mental illness understood?" I was still uneasy about the expression. Davidson and Roe (2007) identified two complementary meanings of recovery: (clinical) recovery *from* mental illness or improvement is just as, or more, common than progressive deterioration; recovery *in* originates from the Mental Health Consumer/Survivor Movement, and refers to a person's rights to self-determination and inclusion in community life despite continuing to suffer from mental illness. This dichotomy may be a reason for the divergent answers given in this question. The divergence in answers raised the question of how to honour the answers given by all panellists. In order to do so, I included both components to reflect the views of all panellists.

Vocation was defined by panellists as a calling. The notion of vocation as a calling emerged in the early 16th century where Martin Luther preached that diligent and responsible practise of an occupational calling was the highest moral achievement possible (Weber, 1958). "Vocation refers to more than mere dedicated service in one's occupation. It refers above all to the whole theatre of personal, communal, and historical relationships in which one lives" (Kolden, 1983, p. 383). Secular notions of vocation as a calling are defined broadly as an occupation that a person is drawn to pursue, expects to be intrinsically meaningful and enjoyable, and sees as central to his or her identity (Berg, Grant, & Johnson, 2010; Wrzesniewski, McCauley, Rozin, & Schwartz, 1997). The broad definition of vocation aligns itself with theories of occupation where "occupation is an important mode through which human beings, as organisms-in-environment-as-a-whole, function in their complex totality" (Dickie, Cutchin, & Humphry, 2006). This definition of vocation was captured in the responses of the panellists so it seems very much a culturally entrenched ideal. Research on work as a calling suggests that vocation being more than "just a job" brings psychological benefits such as increased life, health, and job satisfaction (Hall & Chandler, 2005; Heslin, 2005; Wrzesniewski et al., 1997).

Although panellists embraced this broad definition of vocation, it must be noted that people have varying orientations to work. Where an employee perceives work with an instrumental orientation (i.e. the primary meaning of

work is a means to an end, such as acquiring income), they may become detached from their work and work environment (Blauner, 1964). Certainly in the previous phase of this research, participants identified work as a means to earning an income in order to support the lifestyles they wanted. In these instances, vocation as a calling may be something that people pursue in different occupational domains.

Vocational recovery has been described as the process through which people with serious mental illness attain or regain their role as workers and reintegrate into the workforce (Dunn et al., 2010). Describing vocational recovery as more than just attaining competitive employment (Russinova et al., 2002), allows the nuances associated with both *vocation* and *recovery* to be explored and emphasised. In this way, the framework allows for personal vocational recovery journeys to be included. For example, a younger person in an educational environment, or an older person after retirement, or a parent with caring duties who is not in the workforce may all be incorporated into the framework.

The Framework for Facilitating Vocational Recovery in Mental Illness is well-aligned with previous research on recovery domains, where recovery is still seen as an evolving concept (Liberman & Kopelowicz, 2005). Although there are many personal recovery factors (Slade, 2009) within the framework, panellists also identified clinical recovery factors, which are consistent with previous research showing that both domains are complementary (Roe, Mashiach-Eizenberg, & Lysaker, 2011).

In describing vocational recovery, individual and contextual factors were cited by participants, similar to research by Dunn et al. (2010). However, where these researchers specified having confidence and motivation to work, work-related skills, assessing person-job fit, creating work opportunities, receiving social support, and having access to consumer-oriented programs as factors in successful attainment of employment, panellists in my study identified

elements that expanded on these factors, which have been organised according to their ecological levels.

An interesting point is that employment readiness was mentioned in Dunn et al. (2010) study, as well as in the findings of this phase. As discussed in Chapter One and Two, employment readiness is a controversial issue for people with mental illness. Panellists identified readiness factors as facilitators to vocational recovery. Supported employment, and in particular IPS has been shown to be an evidence-based model for people with mental illness. Interestingly, Roberts and Pratt (2007) argued that the screening criteria for supported employment were related to employment readiness factors. From their review of supported employment research, they concluded that employment readiness was important in planning services to support a person's achievement of his or her employment goal. The findings of this phase revealed that a similar importance was given to employment readiness, with less of an emphasis on IPS. This may be because of the lack of IPS within the services available in Western Australia. This point was explored further in the next phase of the study.

Goffman (1961) and Wolfensberger and Thomas (1994) described the role of the mental patient and client respectively as a pervasive role that is primary, defining, and one that fills the most time, so much so as other roles become fewer and less recognised. According to Wolfensberger and Thomas (1994), people internalise these roles because they are systematically provided with opportunities to perform behaviours related to these roles. In time, they become the devalued role, and are seen as such by themselves and society. Having a life-defining role as a mentally ill client precludes a person from engaging in constituents of "the good life". Wolfensberger, Thomas, and Caruso (1996) listed things that intertwine with the good life, which had some similarities to the findings in this phase. They listed "work that can be invested with meaning", which was how panellists defined vocation; and "having a say in important decisions affecting one's own life", which was expressed similarly by panellists as having choice and self-determination in vocational activities

(Wolfensberger et al., 1996, p. 13). Wolfensberger, et al. also listed "opportunities and expectancies that enable one to discover and develop one's abilities, skills, gifts, and talents" as part of the good life (Wolfensberger et al., 1996, p. 13). This was related to panellists' views on facilitators of vocational recovery, where creating a space to grow was seen as important.

Vocational recovery can contribute to a good life for people with mental illness. Many of the universal good things in life were mentioned by panellists in terms of facilitators to vocational recovery. Besides providing individualised support, it was deemed that connectedness through meaningful employment; and citizenship through contribution, and recognition of such were important in vocational recovery in mental illness. Citizenship was identified as an individual level facilitator to vocational recovery. Citizenship, has been defined as a strong connection to the rights, responsibilities, roles, and resources that society offers to people through public and social institutions, and relationships involving close ties, supportive social networks, and life in one's community (Rowe & Baranoski, 2000; Rowe, Kloos, Chinman, Davidson, & Cross, 2001). This belonging echoes the themes that were present in the first phase of this study.

Although the Framework for Facilitating Vocational Recovery in Mental Illness focussed on enabling aspects of vocational recovery, Delphi panellists also identified barriers that existed in Western Australia based on their experiences. These barriers were mainly located within the macrosystem (the environment, society, mass media, and the public), the exosystem (the policy context), the microsystem (vocational and support services, employers, and family and peers), and the mesosystem (the interaction between the microsystem supports). The barriers that were identified were a mix of qualitatively different and opposing factors to the facilitators that were identified. These findings led to the third phase of the research, where I explored how local services encouraged vocational recovery in mental illness, and analysed the barriers to vocational recovery in mental illness in the Western Australian context.

5.6 Conclusion

The Delphi method enabled the collection and analysis of stakeholder knowledge on the subject of vocational recovery, which then provided the basis on which to develop a definition of vocational recovery and a Framework for Facilitators of Vocational Recovery in Mental Illness to inform policy and practice. In reviewing the results of this phase, I realised that there were two sections of the Framework for Facilitating Vocational Recovery in Mental Illness that remained under-developed. Firstly, many of the challenges panellists described in this phase were not addressed in how vocational recovery could be promoted for people with mental illness. I felt this important issue needed further consideration in the Western Australian context. Considering the Western Australian mental health system in terms of vocational recovery would allow these challenges and the strategies to address them to be examined closely. Secondly, recommendations for "better support" for service providers did not include specifics about what that meant in practical terms. These specific areas were embedded into the methods of the third and final phase of this research project to ensure they were addressed. The next chapter describes the verification of this framework using a case study approach of how vocational recovery is actualised in Western Australia, and analyses the systemic and practice domains of vocational recovery in mental illness.

Chapter 6: The Challenges of Implementing Vocational Recovery in Practice

6.1 Introduction

In the previous chapter, a definition of vocational recovery and a Framework for Facilitating Vocational Recovery in Mental Illness were developed through a process of seeking consensus amongst experts and service providers. The findings of Phase Two reported in that chapter lead to key questions posed in this chapter. In agreement with a now well-developed literature (Leamy et al., 2011), there was a lack of consensus from the Delphi panellists about what constitutes *recover*y in mental illness. The extent to which recovery principles have been adopted in Western Australian mental health services was an issue identified in Phase Two data and was indicated again in the findings of the third phase of the study, which is reported in this chapter. This chapter aims to explore and analyse how local services encouraged vocational recovery in mental illness, as described by the framework from Phase Two.

As in Chapter 5, I again draw upon the ecological framework to help explain the facilitators and barriers to vocational recovery in mental illness. The ecological model clarifies how the macrosystem (the environment, society, mass media, and the public) and the exosystem (the policy context) influence the microsystem (vocational and support services, employers, and family and peers) and mesosystem (the interaction between the microsystem supports), as well as people with mental illness. The findings in Phase Two of this research reported in the previous chapter showed that the policy context and vocational services were major barriers to vocational recovery in mental illness. These key systemic and service challenges to vocational recovery in mental illness will be outlined in this chapter and discussed in relation to a case study of selected local services.

6.2 Research methodology

The case study is considered an ideal methodology for holistic, in-depth investigation (Orum, Feagin, & Sjoberg, 1991). The case study was defined as: "an empirical inquiry that investigates a contemporary phenomenon within its real life context, when the boundaries between the phenomenon and the context are not clearly evident, and in which multiple sources of evidence are used" (Yin, 2003, p. 13). Case studies investigate contemporary phenomena within real-life contexts for a given period of time. They allow the "close examination of people, topics, issues, or programs" (Hays, 2004, p. 218). According to Yin (2003), there are three main categories of case studies – exploratory, explanatory, and descriptive. Exploratory case studies aim to generate hypotheses for later examination (Yin, 2003). The purpose of explanatory case studies is to define how or why an experience took place, and suggest "clues to possible cause-and-effect relationships" (Yin, 2003, p. 7). Descriptive case studies are used to develop a document that fully illuminates the intricacies of an experience (Stake, 1995).

The descriptive case study was selected for this phase of the study in order to develop an understanding of how vocational recovery was expressed in the Western Australian mental health system. This approach was chosen because it describes the phenomena and real-life context in which vocational recovery, including its facilitators and barriers, occur within the local context and services. Descriptive case studies are based on theory. The Framework for Facilitating Vocational Recovery in Mental Illness has been used as a theoretical basis of this case study. The descriptions of vocational recovery developed through Phase Two of this research assisted in defining the theoretical constructs under which mental health vocational programs operate and respond to the needs and vocational aspirations of people with mental illness. The single case study design was chosen due to its representative nature (Yin, 2003). The study also corresponds to Stake's (1995) definition of an instrumental case study, where the research focuses on providing an insight

into an issue, in this instance the policy and service responses to vocational recovery in Western Australia.

6.3 Method

6.3.1 Overview of Phase Three

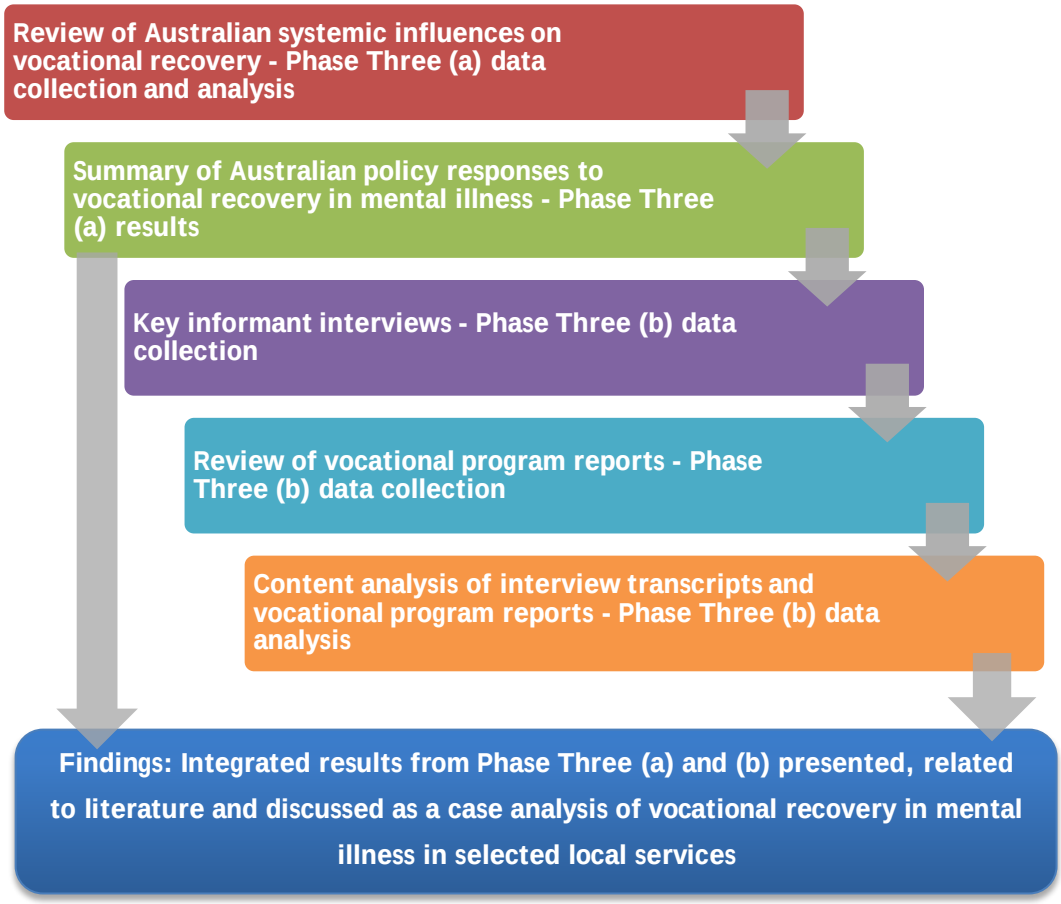
There were multiple data sources informing this case study. Case study data trustworthiness was enhanced through the linkages between the four data sources; namely, a review of contemporary policy documents, key informant interviews, a review of service program documents, and a literature review (Stake, 1995; Yin, 2003). This triangulation of data is achieved when two or more sources of evidence are used to gather information (Lysack, Luborsky, Dillaway, & Kielhofner, 2006).

In order to organise systematically the large amount of data this generated, the case analysis was divided into two discrete phases. Phase Three (a) comprised a review of policy documents and web-based sources relevant to Australian systemic influences on vocational recovery. Whereas a general description of mental health and vocational services was provided in Chapter One, this section of the chapter sets out the key systemic influences in detail. Data collection and analysis was performed to explore specifically the nature of political and social commitment from both Federal and State governments regarding vocational recovery in mental illness. The results provided a systemic and political backdrop to investigating selected services in the local context. Phase Three (b) involved reviewing vocational program reports and key informant interview transcripts from interviews conducted within this phase of the research. These were used as data sources to describe vocational recovery in local services. Analysis was performed to uncover themes and patterns, and converging lines of inquiry from Phase Three (a) and (b) were explored. Finally, the collaborative evidence from both phases was integrated with a broader literature review which included other national and international academic investigations, critiques and responses. The literature

review was another source of evidence in the case analysis, which involved accessing journal articles, as well as news reports that were relevant in order to capture a broad view of local issues and the impact of the ever-changing services on vocational recovery in mental illness. The results and discussion sections of Phase Three are presented as an amalgamation of findings in one section in order to include all sources of data. Figure 6.1 describes the data sources and methods used in this phase of the study.

As this phase was a descriptive case study, how vocational recovery occurred in the local context is described in the findings section of this chapter. Details regarding data collection from the interviews are specified in the next section.

Figure 6.1: Overview of the methods used in Phase Three



6.3.2 Phase Three (a) data collection: Review of Australian systemic influences on vocational recovery

A literature search was conducted to review Australian social and economic policies, guidelines, strategies, and reform documents pertinent to vocational recovery in mental illness. The objectives for the review were to provide an overview of the policies in the field, including the main ideas, models, and debates; and to tease out the implications of these for vocational recovery in mental illness.

A search for relevant documents was performed using electronic databases and websites. A computer-aided literature search using Informit database (2000 to 21 September 2013) and Global Health database (2000 to 21 September 2013) was conducted. OVID was used to search these library-based databases. Searches were also undertaken online using the Australian National Bibliographic database and GovPubs through the National Library of Australia website, the Australian Government publications website, the Australian Government Department of Education, Employment and Workplace Relations Freedom of Information website, the Australian Institute of Health and Welfare website, and the Google search engine. The key terms used for the searches were: mental illness, mental health, vocation, recovery, work, employment, education, training, policy, guidelines, and strategy (with various typographical modifications). Documents were limited to those published in English and available through the relevant institutional libraries and websites.

6.3.2.1 Selection Criteria

Consistent with the scope of this review, policy documents, guidelines, inquiries, strategy documents, and submissions published in English pertaining to vocational recovery in mental illness were identified according to the abovementioned criteria. Only Australian Federal and Western Australian state documents were included. Documents regarding other states and territories were excluded from this review because it was assumed that the

major influences to vocational recovery in mental illness in Western Australia would be Federal and local.

6.3.2.2 Study Selection

Full copies of documents identified by the search, and considered to meet the inclusion criteria, were obtained for content analysis. Documents identified through the reference lists of these documents and other bibliographic searches were also considered for this component of the review.

6.3.2.3 Data Extraction and Analysis

Data pertaining to specific themes that were relevant to vocational recovery in mental illness were extracted by referring back to the ecological framework of vocational recovery. The summary of these themes are shown in Table 6.1. Subsequent to summarising the themes, Australian policies were critically reviewed in order to provide a clear picture of the political climate that shaped vocational recovery in mental illness during the duration of this study.

6.3.3 Phase Three (a) Results

Table 6.1: Chronological table of documents and vocational recovery themes they address

Date	Policy, strategy, or guidelines	Jurisdiction	Key themes pertaining to vocational recovery
1986	Disability Services Act (1986)	Federal	Three streams of specialist employment services for people with disabilities: ▪ Sheltered employment; ▪ Introduction of open employment;

			▪ Vocational rehabilitation.
1996	Western Australian Mental Health Act (1996)	State	Governing structure of mental health care in Western Australia. Legislated admission, treatment, and post-discharge support in relation to involuntary patient care; Community treatment orders.
2003	Third National Mental Health Plan (Commonwealth of Australia, 2003)	Federal	Part of the priority themes were to increase: ▪ The adoption of a recovery orientation to mental health service provision; ▪ Access to psychosocial, rehabilitation and recovery programs, including vocational programs; ▪ Equitable access to employment services; ▪ Integration between services to reduce service system gaps.
2006	National Action Plan on Mental Health 2006-2011 (2006)	Council of Australian Governments: Federal and State	Commitment to increase community and employment participation of people with mental illness. Inception of Personal Helpers and Mentors (PHaMs) to assist people with mental illness in managing their daily life activities and live

			independently in the community. Funding provided for a ten site trial of the IPS model of employment assistance for people with mental illness for three years from 2007.
2006	Welfare to Work Act (2006)	Federal	Changes to the Disability Support Pension where allowed number of working hours dropped from 30 to 15 per week. Disincentives to work included the loss of the Disability Support Pension card and its associated cost savings.
2009	National Mental Health Strategy comprising the National Mental Health Policy 2008 and the Fourth National Mental Health Plan (Commonwealth of Australia, 2009) underpinned by the Mental Health Statement of Rights and Responsibilities (Commonwealth	Federal	Strategy: aimed to reduce impact of mental disorders, and assure the rights of people with mental illness. Policy: vision for a system that enables recovery, ensures access to effective and appropriate community support to enable community participation (including vocational activities). Plan: Emphasised social inclusion, employment, and recovery.

	of Australia, 2009)		
2009	National Mental Health and Disability Employment Strategy (Department of Education, Employment and Workplace Relations, 2009)	Federal *New Labour government	Employment service delivery reforms: ▪ Job Services Australia; ▪ DES; ▪ Supported employment programs. Resulted in greater choice for service users.
2010	Mental Health Commission commenced operation	State	Reform mental health services within Western Australia to improve person-centred recovery supports and services
2011	Senate inquiry into the administration and purchasing of DES in Australia (2011)	Federal	Recommended: ▪ Alternative purchasing models for DES specialist provider services; ▪ The development of a robust and quantifiable quality assessment mechanism that is incorporated into the DES performance framework.
2011	Budget (Australia Government of Health and Ageing, 2011)	Federal	▪ Additional funding given to mental health services; ▪ New wage subsidies to encourage employers to recruit and retain jobseekers with mental illness;

			▪ Extra funding for PHaMS; ▪ JobAccess expanded to include professionals in mental health.
2012	Australian Government response to the Senate Education, Employment and Workplace Relations References Committee's Report: The administration and purchasing of DES in Australia	Federal	Responses: ▪ Alternative purchasing models for DES-ESS specialist provider services – not supported; ▪ DES providers have to meet Disability Service Standards that cover issues such as privacy, dignity, value, and employment conditions of a person with disability, as well as skills and training for DES provider staff working with people with disability.
2012	National Mental Health Commission commenced operation and published A Contributing Life: the 2012 National Report Card on Mental	Federal	Functions to monitor, assess, and report on how the mental health system is performing and its impact on consumer and carer outcomes. A key recommendation was to increase the levels of participation of people with mental health difficulties in employment in

	Health and Suicide Prevention (National Mental Health Commission, 2012)		Australia to match best international levels. Support for evidence-based approaches, such as IPS in promoting participation in employment.
2012	Ten Year Roadmap for Mental Health Reforms (Council of Australian Governments, 2012)	Federal	Improving social and economic participation of people with mental illness was listed as a priority.
2012	The House of Representatives Inquiry into Mental Health and Workforce Participation (Parliament of the Commonwealth of Australia, 2012)	Federal	Recommended strategies to improve: ▪ Intersectoral collaborations between government, community, clinical, community, health, employment, education, and training services; ▪ The capacity of people with mental illness, their families, community members, employment consultants, employers, and co-workers in responding to the needs of people with mental illness;

			▪ Stronger partnerships with peak bodies in tertiary and vocational sectors to improve support of people with mental illness; ▪ The support of social enterprises that effectively transition people with mental illness into open employment.
2012	Mental Health Statement of Rights and Responsibilities (Commonwealth of Australia, 2012)	Federal	Mental health consumers have equal opportunities to access and maintain education and training, and work and employment. Services have the responsibility to: ▪ provide a range of coordinated service options across social support, health and mental health domains ▪ provide appropriate and current education and training to the staff of the service about mental health problems and mental illnesses,
2013	Australian Government Response to the House of Representatives	Federal	Agreement that DES providers need to provide evidence of expertise in working with people with mental illness

	Inquiry into Mental Health and Workforce Participation		
2013	National Framework for Recovery-oriented Mental Health Services: policy and theory (Commonwealth of Australia, 2013)	Federal	Consistent approach to recovery-oriented service delivery
2013	National Disability Insurance Scheme Act (2013) and launch of DisabilityCare Australia in Western Australia (Commonwealth of Australia, 2013)	Federal and State	Includes people with mental illness and promotes: ▪ personal choice and control ▪ learning, and social and economic participation
2013	Creation of the Department of Education and the Department of Employment on 18 September 2013 out of the former	Federal **New Coalition government	Evidence of further changes in attempts to set up the right bureaucratic structure to govern employment and training.

	Department of Education, Employment and Workplace Relations.		

*The Labor government was voted in on 3rd December 2007 after an eleven year period of a Coalition government consisting of the Liberal and National parties.

** The Liberal-National Coalition defeated the Australian Labor Party on 18th September 2013

Since the Disability Services Act in 1986, there have been four legislative changes, seven federal policy documents, and two inquiries relating to vocational recovery in mental illness. This activity is indicative of increasing recognition of the support needed for people with disability including people with mental illness.

6.3.3.1 Legislation and governance

The Western Australian Mental Health Act 1996 (State of Western Australia, 1996) legislated the governing structure of mental health care in Western Australia, empowering the Minister for Health to ensure the delivery of mental health services in Western Australia. It also legislated admission, treatment, and post-discharge support in relation to involuntary patient care and community treatment orders. On 8th November 2012, a draft of the Mental Health Bill (State of Western Australia, 2013) was tabled in Parliament to repeal the current Act and to bring mental health legislation into line with current community expectations, to codify good practice from an Australian and worldwide perspective, and to further emphasise the importance of human rights, particularly given that Australia is a signatory to the United Nations Convention on the Rights of Persons with Disabilities (United Nations General Assembly, 2006). The Mental Health Bill (State of Western Australia, 2013) established a legislative framework for the treatment, care, support, and

protection of people with mental illness, and the recognition of the role of carers and families in providing care and support to people with mental illness.

Over a ten-year period there were extensive reviews, consultations, and scrutiny in drafting the Bill, with advice sought from the public, world experts, and key stakeholders. The Bill was a significant improvement on the Mental Health Act (State of Western Australia, 1996) in protecting the rights of people with mental illness in Australia and supporting the responsibilities of clinicians in balancing quality of care for people with mental illness with community welfare.

There were three Commonwealth Government departments that were responsible for the policies relevant to vocational recovery of people with mental illness. These departments were the Department of Education, Employment and Workforce Relations (DEEWR), the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), and the Department of Health and Ageing (DoHA). DEEWR was responsible for national education, employment, and income support policies. FaHCSIA was responsible for disability benefits policies and the implementation of community-based mental health initiatives. DoHA was in charge of national policy and programs to improve mental health outcomes. In order to improve the low workforce participation by people with mental illness, the Commonwealth Government of Australia implemented a number of policy initiatives over the timeframe used for this study. The details of these initiatives during the time of this research are detailed as follows.

In 2006, The Council of Australian Governments made a commitment to increase community and employment participation of people with mental illness as part of the National Action Plan on Mental Health 2006-2011 (Council of Australian Governments, 2006). This policy also provided funding for 900 Personal Helpers and Mentors (PHaMs) to assist people with mental illness in managing their daily life activities and live independently in the community. Part of this strengths-based, recovery-oriented assistance service included

accessing employment support services. Since PHaMs commenced in 2007, more than 21,000 people with mental illness have utilised the service (Department of Families, Housing, Services, & Indigenous Affairs, 2013). The Commonwealth Government 2011-12 Budget allocated additional funding over five years to expand PHaMs services to assist about 3,400 people with mental illness. They also introduced a new component of the PHaMs activity to specifically help people with mental illness who were on, or claiming, income support or the Disability Support Pension and who were also engaged with employment services. This funding was specifically aimed at reducing personal, non-vocational barriers to participation in vocational activity, such as work or education (Department of Families, Housing, Community Services and Indigenous Affairs, 2013).

In 2006, Welfare to Work reforms were introduced by the Coalition Government, where the allowed number of working hours without loss of the Disability Support Pension reduced from 30 to 15 per week. This had limited impact on the continual growth in the Disability Support Pension population. The number of Disability Support Pension recipients increased from 712,163 in 2006 to 821,738 in 2013 (Department of Families, Housing, Community Services and Indigenous Affairs, 2006; Department of Families, Housing, Community Services and Indigenous Affairs, 2013). According to the 2012/2013 annual report, the latest figures equate to about 5.1% of the Australian working-age population. The Disability Support Pension costs $14.99 billion. In 2012, as a response to the growing welfare burden, the Labour Government made changes to the allowable hours of work so that Disability Support Pension recipients could work up to 30 hours a week and still remain eligible for a part-rate pension.

With a change in government, the National Mental Health and Disability Employment Strategy was released in 2009, which aimed to reform the delivery of employment support services to people with disability, including people with mental illness through DES, which, in March 2010, replaced the former DEN (Department of Education, Employment and Workplace

Relations, 2009). This new strategy continued to utilise a quasi-market system under Job Services Australia, which replaced the Job Network model. Under the Job Services Australia model, former public sector organisations competed with private sector and not for profit organisations for publically funded tenders. A "star rating" system was used to evaluate performance, with higher performing DES providers being rewarded at times of contract renewals. The National Mental Health and Disability Employment Strategy also supported reforms to supported employment programs through advice from an advisory committee (Department of Education, Employment and Workplace Relations, 2009).

The Fourth National Mental Health Plan (Commonwealth of Australia, 2009) emphasised social inclusion and recovery as a central focus. Through the plan, a commitment was made by the Commonwealth Government to ensure that:

> People with mental health problems and mental illness have improved outcomes in relation to housing, employment, income and overall health and are valued and supported by their communities (Commonwealth of Australia, 2009, p. iv)

In the 2011-2012 budget, mental health services were given additional funding, and there were new wage subsidies to encourage employers to recruit and retain jobseekers with mental illness and other barriers to employment (Australia Government Department of Health and Ageing, 2011). Besides these initiatives, PHaMs was given extra funding, as described above, and JobAccess, a free information and advice service about the employment of people with disability was expanded to include professionals in mental health (Government Department of Health and Ageing, 2011).

In conjunction with increased funding, a *Ten Year Roadmap for Mental Health Reforms* (*The Roadmap*) was developed by the Council of Australian Governments (2012) in consultation with service providers, consumers, researchers, and carers. The voices of consumers and carers were seen as particularly important to this development, which was indicative of

acknowledging them as central to personal recovery. *The Roadmap* was developed as a national framework for the focus or renewal of related policies and strategies such as the National Mental Health Policy 2008 (2009) and the Fourth National Mental Health Plan (2009) in order to map the ongoing reform that is necessary to achieve the vision of the Australian Government. According to the Council of Australian Governments (2012), this vision was for:

> A society that values and promotes the importance of good mental health and wellbeing, maximises opportunities to prevent and reduce the impact of mental health issues and mental illness and supports people with mental health issues and mental illness, their families and carers to live full and rewarding lives (p. 6).

The House of Representatives Inquiry into Mental Health and Workforce Participation (Parliament of the Commonwealth of Australia, 2012) was established in 2011 to study the barriers to employment, education, and training of people with mental illness; and to recommend strategies to improve intersectoral collaborations between government, community, clinical, community, health, employment, education, and training services. It also aimed to develop ways of improving the capacity of people with mental illness, their families, community members, employment consultants, employers, and co-workers in responding to the needs of people with mental illness (Parliament of the Commonwealth of Australia, 2012). The House of Representatives Inquiry into Mental Health and Workforce Participation made a number of recommendations that were responded to by the Australian Government in February 2013.

A revised version of *Mental health statement of rights and responsibilities* was released in 2012 to provide an overarching framework to guide policy and practice, and inform consumers and carers. The Statement was revised to reflect recent developments in the language, concepts, and legislative context of contemporary mental health and human rights in Australia (Commonwealth of Australia, 2012). This framework stated that people with

mental illness had the right to equal opportunities to access and maintain vocational activities such as education, training, work, and employment.

Preliminary conclusions from this phase of the research were that there were:

- a profusion of policy documents emanating from Federal and Western Australian government that had an impact on vocational recovery in practice;
- many changes in employment support services; and
- despite the constant reform, there were no significant increase in employment participation rates and no significant decrease in DSP recipients.

The results from Phase Three (a) will be integrated into the themes from Phase Three (b) to form the case analysis findings that describes vocational recovery in the selected services in the local context.

6.3.4 Phase Three (b) data collection: Key informant interviews and review of vocational program reports

The data used for this phase were from key informant interviews (the details of which are provided in the next section), and reports and documentation provided by key informants. Thematic analysis was performed on these sources of information to identify concepts that were relevant to vocational recovery. Thematic analysis involved extraction of relevant themes from the sources and some explicit interpretation. Two vocational program reports, specifically the *Voices at Work* and the *Arts Pathway* projects were also reviewed. These reports were provided by key informants as examples of projects that were facilitators of vocational recovery. The *Voices at Work* project was an 18-month pilot project run by a Western Australian non-government organisation. The project aimed to support people troubled by distressing voices to reduce the barrier their voices posed in gaining and sustaining employment. The *Arts Pathway* project was a discrete eight-month

project that was run by a local service provider that prepared people with barriers for the open employment market in a creative way. It was designed to give individuals a chance to learn creative art skills whilst developing life and employability skills. Both projects were completed and according to key informants, they had not been renewed.

I developed the questions used in data collection from the framework of vocational recovery in mental illness. These questions fulfilled the broad objectives of the case study, i.e. to explore how local services facilitate vocational recovery in mental illness. The interviews were also an opportunity to confirm the relevance of the Framework for Facilitating Vocational Recovery in Mental Illness and the preliminary conclusions made in Phase 3a of the research. Table 6.2 was used as a reference for a holistic view of how data was collected and analysed during this phase.

Table 6.2: Data Collection Strategy for Phase Three (b)

	Questions	**Sources of information**
1.	How relevant and applicable is the framework of vocational recovery to services in Western Australia?	Key informant feedback about the vocational recovery framework
2.	How are services facilitating vocational recovery?	Key informant interviews, vocational program reports
3.	What more do services need to do to facilitate vocational recovery?	Key informant interviews, literature review
4.	What resources are required to support vocational recovery? Are these resources currently available?	Key informant interviews, government policy documents, literature review
5.	What individual, social, and systemic challenges to vocational recovery do people with mental health issue face?	Key informant interviews, government policy documents, literature review
6.	What strategies do services use to answer barriers to vocational recovery?	Key informant interviews, vocational program reports
7.	How have the recent changes in services affected service users in relation to vocational recovery?	Key informant interviews, government policy documents, literature review

6.3.4.1 Participant selection for interviews

As described in chapter one of this thesis, DES providers were government funded employment services that assisted people with disabilities in obtaining competitive employment in the open market. Besides mainstream DES providers, non-government organisations also offered more novel vocational programs that had been funded either through specific grants or through different government agencies. Although these novel or special interest programs tended to be shorter-lasting, discreet projects, they held promise in facilitating vocational recovery in mental health consumers. Ideally these services would have contributed to the case study data but during the data collection phase the DES providers lacked the available resources to participate in the research because of the changes in, or loss of service contracts. Further details and my reflections about this occurrence are provided in Chapter Seven. As such, government and non-government mental health service providers who referred people with mental illness to DES providers, and also provided vocational services were approached to participate in this phase of the research.

Purposeful sampling was used to recruit five key informants to this phase. According to Patton (1990), "the logic and power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research…" (p. 169). Nine key informants who each had over 15 years' professional experience in mental health services and had served in executive, managerial, and consultative positions in local mental health services were personally approached by one of my PhD supervisors and then by me. From these, five agreed to participate and were emailed information about this phase of the study (Table 6.3). Those who declined to participate in this phase cited lack of time as the main factor that prevented their involvement. The key informants who were interviewed had first-hand knowledge of the facilitators and barriers to vocational recovery in service

provision. In order to protect the identity of participants, pseudonyms have been used.

Table 6.3: Description of key informants

Participant	Professional position
Jim	Non-government organisation manager
Anna	Non-government organisation program director
Mark	Government mental health service senior clinician
Sara	Service manager and mental health advocate
Colin	Non-government organisation manager

6.3.4.2 Interviewing participants

Once key informants agreed to participate in the study, they were either interviewed in person or surveyed through email. Key informants were given a choice in how they responded to questions due to their busy schedules. Two key informants chose to respond by email, and three chose to be interviewed. I contacted key informants directly by telephone to organise mutually convenient times and places to conduct the interviews. Data were collected between 19th March 2013 and 24th August 2013.

Face-to-face semi-structured interviews were conducted at a time of each key informant's choosing in convenient locations within the Perth metropolitan area. Venues included three mental health service offices.

Prior to the interviews, key informants were provided with an electronic copy of a summary of findings from Phase Two, including a the definition of vocational recovery and a draft of the Framework for Facilitating Vocational Recovery in Mental Illness, along with a list of questions for their consideration. I started each interview with an introduction to the research and findings in Phases One and Two, and described the purpose of the interview. Each key informant gave written informed consent prior at the commencement of each interview. Interviews were digitally recorded and

professionally transcribed verbatim. Interviews were between 70 and 80 minutes in length.

Key informants were asked to comment on the findings from Phase Two and where appropriate, give a brief description of the mental health service they worked in and their role within the service. Subsequent to this, the questions from Table 6.2 formed the basis of the semi-structured in-depth interviews.

6.3.5 Data analysis

Data analysis was performed on a question by question basis. Each of the questions in the data collection strategy was answered by reviewing the sources of information relevant to them as specified in Table 6.2. I read each transcript to extract content in order to answer the relevant question, and if appropriate, the results from Phase Three (a), other relevant documents, records, and literature were drawn upon. Thematic analysis was performed on these sources of information to extract data that were relevant to vocational recovery. The themes were also reflected back to Phase Three (a) results and relevant literature was sourced for a full case analysis and discussion. The data from these different sources were then brought together in a thematic analysis and quotations were selected to illustrate common themes and emergent patterns. These themes were considered in terms of connections and relationships between them. The incorporated results and discussion are presented as findings in the next section.

6.4 Phase Three findings

The findings of this phase of the study are presented as themes about how vocational recovery in mental illness was realised in Western Australian services across the timeframe of the study. Specifically I sought to identify and explain the facilitators and barriers to implementation of a vocational recovery approach within services in the local context. This section outlines the many

interconnected barriers to vocational recovery in mental illness. The first two barriers, namely, the limited and fragmented mental health services and the lack of specialised mental health employment services for people with mental illness were described mainly through reviewing government policy documents. Other barriers, such as the limitations in the local mainstream employment model that was supported by government policy; and the lack of focus on vocational recovery in local services were identified through all data sources. These barriers echoed the ones that were identified in the previous chapter. Despite these hurdles, there have been discrete local programs that have promoted vocational recovery during the time of this study. The facilitators used in these programs, as well as those described by key informants are presented in a section on vocational recovery strategies, and the practical application of the Framework for Facilitating Vocational Recovery in Mental Illness is discussed, given the local context of service provision.

6.4.1 Limited and fragmented mental health services

This study was set in Western Australia. As such, it is essential to understand the structure and delivery of mental health services as they existed in the years 2007 to 2013, during which time this study took place. The majority of people admitted to mental health services in Western Australia were between the ages of 15 to 30 years of age (Australian Bureau of Statistics, 2006). As this is a critical period in a person's vocational life, it is important that valid and reliable services across the mental health and employment sectors facilitate participation in vocational activities.

As described in Chapter Five of this thesis, the policy context shapes clinical, welfare, disability, and employment services. Although local legislation and frameworks supported the rights of people with mental illness, policies and practices at a systemic level posed significant barriers to vocational recovery in mental illness. Service silos were discussed in the previous chapter, where a lack of coordination between employment support and clinical services was a

barrier to vocational recovery. Besides making navigating service systems difficult for people with mental illnesses, this separation also led to delays in the provision of job search assistance (Family and Community Development Committee, 2012). Additionally, employment support services such as DES were inadequately staffed to respond effectively to the vocational recovery needs of people with mental illness. This limitation in service provision was described by all key informants in phase three of this research.

There was a 2012 House of Representatives Standing Committee on Education and Employment Inquiry into mental health and workforce participation in Australia, which recommended a series of reforms to improve the effectiveness of DES providers in supporting people with mental illness who were seeking work. The committee recommended that:

> Any future Disability Employment Services tender process require prospective disability employment services providers to provide evidence of expertise in working with people with mental illnesses (Commonwealth of Australia, 2012, p. xx).

Although this need for specialised service provision was clearly recommended by the committee, the latest tender process saw the closure of Western Australia's only specialised mental health DES provider (Harvey, et al, 2013). Job seekers with mental illness that used that service were referred to various new or existing DES providers that may not have had the level of mental health literacy the specialised service once provided.

People with mental illness in Western Australia did not have a clear sense of how to achieve their vocational aspirations. According to all key informants, this absence of clear pathways to vocational recovery was a result of fragmentation of mental health services. Anna elaborated on this point:

> All of the people working in mental health service I've met, at all levels, see the importance of vocational recovery, and want to do something

> but are hampered by the disjunct between the employment sector's way of working and goals, vis a vis mental health systems and goals.

At the time of this study, public, private, and non-government services delivered mental health care. A broad range of services were provided, which included acute inpatient services, community mental health services, recovery/rehabilitation services, and non-government organisation services such as supported accommodation, employment services, psychosocial support, rehabilitation services, respite, and in-home assistance. General practitioners and other private clinicians also contributed to mental health care.

However, despite the range and number of services, Western Australian services faced similar challenges as the national mental health system, where both systems appeared reactive and fragmented rather than proactive and integrated:

> The [mental health] system is still too crisis-driven, with many people only receiving help when they are at their most vulnerable, instead of help to stay well. There are a number of highly effective services, but they are often patchy and not connected and, for reasons of program design or funding, struggle to deliver a truly integrated service response based around the individual's needs. This fragmentation of services also creates gaps, which prevent people receiving the full range of services that provide an optimal path to recovery… Some 600,000 Australians have severe and debilitating [mental illness] which challenges their ability to live independently and participate in life (Australian Government 2011, p. 1).

The Western Australian Mental Health Commission developed the *Western Australia Mental Health Plan 2020* in order to deliver a government and community approach to providing person-centred supports and services; fostering better connections between public and private mental health services, as well as formal and informal supports, services, and community

services; and a more balanced investment in services ranging from promotion, prevention, and early intervention to rehabilitation and recovery (Mental Health Commission, 2011). This strategic policy addressed the challenges of the number of people who take their own life through suicide, the high level of vulnerability of young people to mental illness, the higher prevalence of mental illness among Aboriginal people, and the deficit in community support and accommodation to assist people in transitioning into the community from mental health services (Mental Health Commission 2011). In a review of services in Western Australia, Stokes (2012) reported that many consumers had never experienced any rehabilitation program, and were left to overcome impairments and motivate themselves to pursue education and employment without formal support. The same review found that rehabilitation and recovery were not a focus of mental health care, and the authors recommended concerted and careful attention be directed towards these areas.

Convolution in mental health services was also evidenced by the fragmentation of public, private, and non-government health services, state- and territory- provided rehabilitation and disability support services, vocational training and higher education. In Western Australia, there was a complex system of vocational services throughout the government and non-government sectors, which influenced vocational pathways for people with mental illness. The mental health services and vocational services for people with mental illness were funded and run separately, with the majority of the former receiving state funding and the latter receiving federal funding. Further complication existed due to health, education, and employment services being structurally located across several sectors and agencies. Although there was considerable overlap between vocational services and other mental health services, fragmentation in service provision existed (King, et al., 2006). The service system was siloed, where completely separate organisations and agencies that lacked convergence or alignment operated without connections with each other. Based on the findings from this phase, the disconnect

between mental health and vocational services was a hindrance to vocational recovery. Many consumers experienced difficulties navigating the system, and consequently many received inconsistent support, fell through the gaps, or exited the system in frustration. Although many services had developed innovative initiatives to facilitate vocational recovery, they often failed to be implemented as a result of fragmentation and lack of funding. Mark explained:

> We've got all these initiatives sitting on the shelf. They don't have the funding. We don't have the funding, we can't meet the need, and that's the sadness and the reality of the system. Like, let's be realistic, we can't just meet every need we identify, but when some of the needs are, as I say, coming back to vocational recovery, are clearly to the benefit of the individuals concerned. It is extremely difficult and often we have to cobble together a network of people of goodwill, whether it's family members, friends, a bit of give and take from all parties concerned, we plug holes where we can. So there is a fair bit of kind of horse-trading where we try and pull as much favours as we can really to try and support the person in the process.

An urgent need for improved connectedness between different services existed, which required greater collaboration between state and federal governments (Mental Health Council of Australia, 2007). It was evident from reviewing the systemic influences of vocational recovery in mental illness that there had been a constant state of reform in Australia in the last ten years. This resulted in a lack of stability, consistency, and coherence in service provision. With constant changes to the sector, service providers operated in crisis mode, and have not been able to consolidate services and focus on providing quality, efficient, and effective services.

6.4.2 Lack of specialised employment services for people with mental illness

To assist in employment, people with mental illness may be directed to one of a number of services that broadly assist people with disabilities and are, at the time of writing, funded by DEEWR. This system of funding incorporated changes in service providers' program requirements implemented by DEEWR as part of the Australian Government's *Welfare to Work* reforms, which aimed to increase participation in work for all people capable of work, including welfare recipients (Commonwealth of Australia, 2005). During the timeframe for the study there were three major government funded employment services for people with mental illness. Disability Employment Services provided job seeking assistance and on-the-job support and training to help people establish and keep their employment in competitive employment in the open market. Australian Disability Enterprises provided more supported employment conditions. Job Services Australia providers delivered assistance to disadvantaged job seekers, including people with disability.

Department of Human Services agencies and non-government providers utilised Job Capacity Assessments through Centrelink (the government agency that provided income support) to determine the work capacity of individuals and subsequently referred them directly to the appropriate agencies for assistance. Job Capacity Assessors may be qualified in occupational therapy, psychology, physiotherapy, exercise science, nursing, social work, or speech pathology and may not have any formal psychiatric rehabilitation training. These allied health professionals functioned as gatekeepers for services, yet it was a requirement that all consumers be assessed even if they had been directly referred to specific services. The assessments determined an individual's medical impairment, work capacity, intervention needs, and referral options.

A number of programs assisted people with mental illness to become job ready or provided job placement. To promote job-readiness, some state funded public health system mental health teams ran pre-employment activities as

part of their living skills programs; however, these were rarely provided in consultation with vocational services. Clubhouses provided transitional employment support and supported employment programs provided paid employment and support within workplaces. Consumers who required job placement, as well as ongoing support to maintain employment were referred to DES providers. Not all people with a disability were referred to a DES. If a person had a disability, but did not require on the job support and was *work ready*, they would be referred to a mainstream Job Services Australia provider.

All DES providers were performance managed by DEEWR for their eligibility to receive future financial support from the federal government through a star rating system. The most important criterion for gaining a high star rating was effectiveness in employment outcomes, that is, job placement and tenure measured at set timeframes, specifically 13-week and 26-week outcomes. This type of outcome-based funding may cause service providers to feel pressured to place consumers in jobs at the expense of job fit (Gates, et al., 2005) and vocational goals. Federal tender processes occurred after two years of service provision for DES providers, and subsequent to the recent tender process for service contracts from 2013-2018, many of the Western Australian based and experienced DES providers, including those with an interest in the implementing evidence-based practices, have been closed down or significantly reduced in size. This included the closure of Western Australia's sole mental health specific service (Harvey, et al, 2013). In their place, many for-profit multinational private businesses and Australia-wide DES providers with unknown track records in working effectively with people with mental illness have been opened. Disability Employment Services providers were allocated three months to scale operations up or down and outgoing services transferred existing consumers to incoming DES providers.

The importance of training and expertise in mental health were mentioned by all key informants, who pointed out that often, employees in DES providers had no clinical training or background to understand some of the complexities of mental illness or disability. This was supported by the Australian

Government Response to the House of Representatives Inquiry into Mental Health and Workforce Participation (2013), where agreement was given to the recommendation that DES providers needed to provide evidence of expertise in working with people with mental illness. All key informants were of the view that training and quality of the staff being employed was important, and they were all critical of service contracts being given to the lowest bidder who hired people who were not trained in this sector. Evidence based approaches to providing optimal employment services for people with mental illness have identified enhanced intersectoral links and integration of employment and mental health services as a key factor in the effectiveness of employment services (Bond, 2004; Bond, Drake, Becker et al., 2008; Dixon et al, 2010). However, having employment consultants who did not have specialist mental health training posed a challenge to the adoption of these approaches.

Although four of the five key informants agreed that DES providers were well placed to potentially support people's vocational recovery in mental illness, Colin pointed out that underlying tensions still existed in referring people with mental illness to specialised services as opposed to mainstream community approaches. He explained:

> If you access disability services, or support services, you're actually, potentially stigmatising that person and you're reinforcing the disability, so by looking at what is available in your community to assist you to meet your dreams and for all the mutual benefits, then that's the way to go.

6.4.3 Limitations in employment models and service provision

Although there had been two changes in government over the course of this study, the policies regarding *Welfare to work* and employment service procurement continued without critical review. Disability Employment Services funding obligations were based on job placements with no focus on vocational recovery in mental illness, and used untested employment models

that lacked an evidence base (Department of Education, Employment and Workplace Relations, 2009). Government policy did not support the implementation of an evidenced-based model of employment for people with mental illness, the IPS model. Literature surrounding the efficacy of IPS was presented in Chapter Two. All key informants agreed that using evidence-based employment models encouraged vocational recovery in mental illness. Anna summarised this view: "From my experience and from the literature I think the best thing mental health services and Disability Employment Services can do is to develop fidelity with the IPS model".

Mental health service consumers were frustrated with the way employment services were provided. A study conducted by SANE Australia suggested that 66% of respondents with serious and persistent mental illness were dissatisfied with the DES provider to which they had been referred (Morgan et al., 2012). All key informants were critical of "DES services being like a production line". They were of the shared view that although many DES providers were using the right buzzwords about person-centredness, it was not universally congruent with their actions and attitudes. Jim expressed concern about people being placed in what he termed: "marginal employment" where "there are a lot of employment support providers where you go for janitor jobs, cleaning jobs, gardening jobs…"

Although DES providers were the mainstay with regard to people with mental illness obtaining employment, service providers were critical of the lack of training, person-centredness, and recovery-focus of the employment consultants. Key informants spoke about not referring to DES providers because it was detrimental to their clients' recovery journeys. In many instances, service providers would support clients' vocational recovery themselves and assist them in building relationships with their communities. Although *ad hoc*, this practice was much more in keeping with recovery philosophy (Anthony, 1993; Corrigan, 2002).

Disability Service Standards for DES providers require practices that are person-centred and support individual needs and goals (Disability Services Standards (DEWR) 2007). However, two out of the three key performance indicators for DES providers were efficiency and effectiveness, where an arbitrary timeframe had been imposed on job placements and outcomes (Department of Education, Employment and Workplace Relations, 2011). The lack of flexibility meant that in reality, DES providers would suspend their clients' services in order to prevent negative statistics regarding the key performance indicators, which was an issue reported by key informants.

In order to safeguard mental health service consumers, Mark spoke about supporting people:

> Before they stood a viable chance of being picked up by a Disability Employment Service provider. Because if not, we send them out to fail. That's not recovery. That's unethical. And what it does it damages the hope and potential that they have for a future, and so we're very concerned about that.

Anna pointed out that the resources were in place, as DES services could potentially support vocational recovery in a way that would deliver a profit for them, but the contractual and reporting settings were a bad fit to the IPS model. Anna, Mark, and Jim emphasised that a change of policy was needed, along with better incentives for the DES sector to be involved in vocational recovery and resources for training mental health and DES staff.

Mark advised that there were "quite a number" of clients who had been referred to DES providers who had negative experiences and failed to obtain employment. In order to deal with this, he said: "Sometimes we pull them [out of the service]. Sometimes services just tell us they put the client on hold to suspend their service, because they don't want to ruin their stats".

This, along with disruptions to service provision with the recent competitive tendering process, posed major barriers to consumers achieving their

vocational recovery goals.

Disability Employment Service Employment Support Service contracts commenced on 1st March 2010 and a competitive tender process was subsequently undertaken by DEEWR for the 2013-2018 program. DES providers that were successful in their tenders commenced service provision on 4th March 2013. Anna summarised the outcome of this process in the Western Australian DES sector:

> Many of the WA based and experienced DES services, including those with an interest in the IPS model have been closed down or significantly reduced in size. In their place are a number of private business multinational and Australia-wide DES services with unknown track records in working effectively to assist people living with mental illness to get and keep jobs.

Jim had similar observations: "access to specialised Disability Employment Services, the specialised Disability Employment Services got axed". He commented that although the Parliamentary Standing Committee and government response explicitly recommended the implementation of the IPS model, "but then they chopped an agency in Melbourne who had built up 34 sites as part of their tender to go down the IPS [route]".

Mark gave an account of what occurred in the clinical setting: "so it's a difficult one when there's such high staff turnover in those sectors. It got even more difficult when I was told that eight out of the 13 local providers lost their funding". In a newspaper interview, a program manager of a local DES commented that some of the six new agencies were profit-driven and not interested in people with mental illness because they were more costly to support. He said that previously, people with mental illness made up about 40% of their clientele, whereas at the time of the interview it had risen to nearly 75% in order to assist people with mental illness who had been turned away from other DES providers (Grant, 2013). Quasi-markets had a tendency towards risk selection (Struyven & Steurs, 2005). Risk selection refers to the

practice where providers focussed their attention on the most lucrative clients, in this instance, jobseekers who were easier to place in order to maximise their financial return. These opportunistic practices were recognised by the Productivity Commission (2002) and reported in research by Murray (2006), Marston & McDonald (2006), and Neville & Lohman (2011).

Mark considered the tender process as poorly managed and devaluing of the efforts of the other service providers, as well as, of the clients themselves:

> I think it was a real indictment on the system… Nobody's talking about keeping inefficient services, but at the same time if there's not even a guarantee the service will be in existence in the next few years, how do you expect the client to trust the process?

He continued to explain that the policy intent and the principles about person-centredness had not been adhered to during the process.

As mentioned in the previous section, pre-employment job-readiness activities were provided through public mental health services. There was disagreement by the key informants about the suitability of IPS versus job-readiness models in vocational recovery in mental illness. Although both Anna and Jim were critical of job-readiness models, Mark pointed out that there was insufficient support from DES providers for people returning to work, due to the tight performance measures that they operated under. This led clinicians to focus on employment readiness prior to referrals to DES in order to make up for the shortfall in ongoing support. He gave an example of how his team was trying to support a young man with what he would find meaningful and purposeful with regards to vocation. However, they realised that to traverse all the fragmented agencies to facilitate vocational recovery was highly labour intensive, and was not supported by the tight budgets they worked under.

The notion of being work ready was a challenge that was identified by both Anna and Jim. Jim explained:

> There's a lot still around in both public and NGOs about getting people work ready. That's the biggest scourge that people that live with mental illness have to deal with. But the prejudice that's behind that in … I would be as dramatic as to say across all mental health service providers, public and non- and that is the notion of work ready. You've got to be work ready before you can get a job. Whether it's a meaningful job is another thing.

Both Anna and Jim were strong advocates of the IPS model, which has been shown to be effective in assisting people with mental illness to obtain competitive employment in America and the United Kingdom. However, Sara, Mark, and Colin saw the benefit in having an adjunct model that emphasised work readiness and offered a range of vocational options, including paid supported employment, agency-contracted community placements, and volunteering. According to Mark, agencies did not support people with mental illness into unpaid employment, which he deemed to be:

> A huge area of unmet need, because lots of clients would like a more meaningful and purposeful relationship with their community. It's not about money. It's about being valued and having something to offer back, but the structures aren't really there.

6.4.4 Lack of vocational recovery in local services

Key informants all agreed that the definition of vocational recovery and the draft of the Framework for Facilitating Vocational Recovery in Mental Illness was relevant to some degree to services in Western Australia. They gave examples of how people with mental illness have benefitted from engagement in vocational activities. However, all key informants held the view that although services have incorporated aspects of personal recovery principles into their programs, there has not been any integration of vocation into recovery programs. Jim spoke of the NGO sector: "organisations have been working for recovery, trying to move towards recovery, but employment has not been in the top five priorities". Colin expressed similar concerns about the

lack of focus on recovery in employment services, "which could actually do more harm than good, because you're actually maintaining chronicity in many instances".

Anna gave an opinion on why this was so: "I think that in the main mental health services do not encourage vocational recovery for structural-systemic-disjunct government policy reasons, but not because they do not see the importance of it". She pointed out that DES policy imperatives were about getting a prevocational placement or work in a competitive market, and there was no focus on whether what they do or how they do it facilitates vocational recovery. She suggested that it would be useful if DES services were to be assessed against their capacity to contribute to vocational recovery.

Sara agreed with this, saying: "We have too many constraints within mainstream employment provision, industrial policy and legislation to be geared towards vocational recovery".

Mark offered a clinical perspective about why vocational recovery had not been a focus of services:

> I think there's a hole when I look at services. It's impossible to pinpoint anything that's kind of standardised across the service, or across the sector, and I think it's still hit and miss depending on who you get as a case manager, who you get as an occupational therapist, or who you can get as a registrar, and in a teaching hospital setting the staff rotation and turnover is reasonably high, and so it is a continual effort for some of the more consistent staff to educate some of the new staff that come and go about the importance of paying attention to the vocational recovery.

Further to this, Sara cautioned that:

> Recovery can be a dangerous term as it is intended to create a space for hope and positive growth, but many services can hijack the term yet still deliver programs that do not support a personal, self-described,

> and directed experience, journey, or concept. I work closely with people in the community and constantly hear stories and experiences of how services dehumanise and depersonalise the individual. I also hear positive stories of good experiences, sometimes the difference is the worker, but I would also hazard to say that a service doesn't support appropriate training or give appropriate support to staff as well. Recovery can just become a catchphrase that becomes quite hollow in content.

There was agreement from all key informants that draft of the Framework for Facilitating Vocational Recovery in Mental Illness served as a strong vision for people to aspire towards; however the existing local employment climate and policies were prohibitive to the realisation of practices that promoted vocational recovery. Jim explained that although his overall impression of the framework was that "it's beautifully crafted vision and words", he remained unsure as to how real it was to have those expectations. He described the framework as "soft" and explained that very little of service involvement in recovery…

> Has led to employment, let alone meaningful employment. What I do know is that a very high proportion of people at the end of the day do want to work. Well, anyone who wants to work would like it to be a good job. So a meaningful job, they enjoy it, they enjoy their environment, they get challenged… but not everyone can achieve it.

Jim's view that vocational recovery was an ideal that was not achievable in the current local context was shared by all key informants. Vocational recovery was an unmet need of people with mental illness in Western Australia. Recently, more people with mental illness in Western Australia have had difficulties getting work due to the failure of the system to provide specialist help for people with mental illness to obtain and keep employment (Grant, 2013). Although people with mental illness have been shown to benefit from engagement in vocational activities such as education, work, employment

(Office of Mental Health, 2004), and volunteering (Young, 2008), there remained a disconnect between current theoretical understandings, policy statements, services, and funding of vocational activities.

6.4.5 Vocational recovery strategies

Key informants spoke about the strategies that services had used, as well as strategies they thought may be used in the future to answer the challenges to vocational recovery. All key informants agreed that although using an IPS model approach was optimal, it was also important to provide avenues of training, education, work experience, supported employment, volunteering, and community engagement as part of a person's vocational recovery in mental illness. These views were in alignment with the Framework for Facilitating Vocational Recovery in Mental Illness that was developed in Phase Two. According to Anna,

> In my experience, people with mental illness want real jobs in the open job market, real pay, not endless pre-vocational experiences or sheltered workshops (now called business enterprises). I have seen many, many, cases where someone's engagement in the work community, and having a valued sense of purpose, has contributed to wellness.

Although Anna and Jim were strong advocates of the IPS model, the other key informants stressed the importance in providing clear vocational recovery based pathways to open, as well as supported and volunteering roles. All key informants shared Anna's view that flexibility between pathways of vocational recovery was beneficial for people with mental illness.

With regards to strategies that had been implemented in the past, Anna, Jim, and Mark described individual practitioners and teams who had attempted to allow employment services to co-locate and integrate with them in accordance with the evidenced-based IPS model. Other services have adopted more

intuitive, less rigorously tested models which focus on a step-wise approach to employment involving pre-vocational training and work experience. These services were based on recovery and person-centred approaches to service provision. Sara described an alternative form of employment that was a collective and socially developed concept of employment that suited the person with mental illness engaged in it, rather than making the person fit the mould of an employee as expected by market-based employment policy, legislation, and workplaces. Services also ran discrete projects that supported people with mental illness' vocational aspirations, such as the *Voices at Work* Project (Richmond Fellowship of Western Australia) and the *Arts Pathway* Project (Ostara DES).

Strategies that have the potential to address the challenges in the future included cultural shifts within the public health system and DES providers so that strong partnerships may be developed in order to implement the IPS model. Jim pointed out that:

> Trust has got to be high. The DES worker has got to have as much access to the system as your senior [clinician], because otherwise they're at a lower rung. And if they're at a lower rung, when they open their mouth it'll be afforded that little bit less weight in the team, right. So we've got more important things to do. Yeah, we'll get to employment, right, but we've got to get this person better first, right. But if I come back and say, well, getting a job is part of that, it's almost the first step in that.

Mark's opinion was that using common recovery-based concepts was a way for employers, employment consultants, and clinicians to work together as a team to use the same language and principles, and to focus their support of people with mental illness. He gave examples of applying the recovery principles in looking at:

> What did we learn from that last relapse? What did we do well? What could we have done better? How do you like things to be done

> differently? How can we explore effective ways about the areas that was an identified gap, and we can collaboratively learn from that process to improve the support we provide.

However, he pointed out that being under-resourced and not having stability in DES providers were barriers to implementing this change. He suggested that a change in funding from:

> A one-size-fits-all approach for everyone... to a system that has some flexibility to meet the person, understand the issues, their lived experience, how they make meaning, what their process of enablement is. What are the processes that keep them stuck where they are, and how do we work and support them so that they can participate in a more meaningful way? And this is where the philosophy of funding is so incongruent with the philosophy of care, about being person-centred, because the funding doesn't seem to match that.

Colin advocated for normalising the employment process, and enabling doors to be opened in the person's community. In his view, it would de-stigmatise mental illness and facilitate personal support and connections that were positive and identity-enhancing. He described having a strong person-centred recovery focus:

> The important tenet is that [the person with mental illness] is an equal partner in this. They're not passive, and we've got to enable the person to be assertive. What are your dreams? What are you hopes? What are your aspirations? What are your passions? What is it you would really like to do?

All key informants hoped that clear vocational pathways would be mapped out in the future, which would be transparent and user friendly for clinicians and service providers in order to improve the process. These flexible, person-centred pathways could include IPS, a step-wise approach involving employment readiness, supported employment, and volunteering pathways.

6.5 Conclusion

The objective of this phase of the study was to explore how the Framework for Facilitating Vocational Recovery in Mental Illness that was developed in Phase Two was realised in the local context, and uncover the facilitators and barriers to vocational recovery within the service context. A single descriptive case study was used, where key informants confirmed that the themes of the Framework for Facilitating Vocational Recovery in Mental Illness encompassed an ideal vision, which were not realised in the current local context. Current Australian practices were identified through policy and legal documents, program reports, funding body requirements, current literature, and anecdotal reports by key informants. The findings of this phase brought challenges to vocational recovery in Western Australia to the fore.

It was evident from the findings of this phase that although the Framework for Facilitating Vocational Recovery in Mental Illness was an idealised notion based on values and principles, the reality in Western Australia was that there were numerous barriers to it being realised. The barriers found in this phase were similar to and expanded on those found in the previous phase. It was unquestionably clear that several interconnected challenges to vocational recovery in mental illness exist, such as incoherence and instability of Commonwealth policy, fragmentation of mental health services, a lack of specialised employment services for people with mental illness, the use of untested employment models, an absence of clear pathways to vocational recovery, a lack of focus on vocational recovery in local services, and DES providers having to meet key performance indicators. These posed separate challenges to vocation, recovery, and people with mental illness, and rendered the vocational recovery in mental illness journey a difficult path to travel.

Recovery in mental illness is the journey a person undertakes in order to live fulfilling lives, even though they may experience limitations of mental illness (Anthony, 1993). This involves establishing valued roles, connections, and purpose within the community. Vocational activities such as employment have been identified as an inherent part of a person's recovery journey; however, the

reality was that it was of a low priority for service providers, which resulted in people with mental illness becoming at risk of being placed in marginal employment or not being employed.

This phase of the research confirmed elements in the Framework for Facilitating Vocational Recovery in Mental Illness and provided a description of vocational recovery in the Western Australian context. The findings may be used by mental health vocational service providers to gain a better sense of how their programs may facilitate vocational recovery for people with mental health issues. They may then use these insights to amend programs to meet service users' needs and further promote vocational recovery. Government policy limitations prevented DES providers from developing fidelity with the IPS model of employment for people with mental illness in the competitive job market, and a stepwise approach in paid (sheltered) and volunteer work. An account of vocational recovery in service provision was presented in this chapter, which may assist policy makers to better understand how vocational recovery may be promoted so that practices, programs, and policies may be adjusted as required.

Chapter 7: Conclusions and Recommendations

7.1 Introduction

In this thesis, I have sought to describe and analyse how people with mental illness endeavour to establish and achieve their vocational goals within the context of recovery. Evident, to this point is the major finding that while a number of people, including those with mental illness, may seek an ideal called *vocational recovery*, the achievement of this ideal involves a complex journey fraught by challenges and hurdles. Although living with symptoms of mental illness can limit a person's participation in vocation, systemic and practice issues pose far greater challenges.

In explaining this complexity I have answered the research questions that were detailed in Chapter One. I have described what vocation means for people with mental illness and what their vocational aspirations and experiences are. I also then explored what facilitators and barriers people with mental illness experienced in their vocational journeys and how these impacted on paths and services chosen. In turning to the perspectives of other key stakeholders, principally those involved in service provision, I sought to explore how vocation fits into current understandings of recovery and how vocational recovery might be defined. I then examined how vocational recovery was realised in Western Australia in terms of aligning principles with practice when the services most needed were disparate and reduced.

The responses to these questions inform the ways in which services respond to the vocational needs of people with mental illness. The previous chapters comprised the context and background of the thesis; a literature review; a description of the methodologies used; and the methods, analyses, and findings of three research phases. This chapter provides a review and analysis of the overall conclusions in relation to the key research question, specifically, how people with mental illness establish and achieve their vocational goals within the context of recovery, and examines the ways forward in terms of policy and research implications and opportunities. This chapter also provides

my reflections on the research process, addresses limitations of this study, and provides the major research findings and an overall conclusion to the thesis.

7.2 Vocational Recovery in Mental Illness – drawing conclusions

In attempting to draw together the previous components of the study, which were presented in three phases, I return to the Vocational Recovery in Mental Illness Model that was developed in Phase Two of the study and presented in Chapter Five of this thesis. Through this theoretical lens a more complete understanding of the topic as it is understood in a local context is presented. As detailed in Chapter Five, Figure 7.1 is the diagrammatic representation of the model. In essence, this model separates out the personal, practice-based, interactional, systemic, and environmental issues that affect vocational recovery. However, it also acknowledges their interrelationships and changes that may occur over time. The facilitators and barriers to vocational recovery in mental illness were presented in Tables 5.4 and 5.5 in Chapter Five of this thesis. Metaphors relating to journeying are used in this summation of the research in order to describe the abstract notion of vocational recovery in mental illness from the perspective of those with mental illness and those who provide services to this group.

Figure 7.1 Vocational Recovery in Mental Illness Model (based on Bronfenbrenner, 1977)

7.2.1 The vocational journey

Central to this thesis are the concepts of vocation and recovery. While the thesis did not set out to describe vocational recovery journeying, the metaphor of the journey emerged through the findings. Vocational journeying can be a meaningful part of a person's life journey, and the findings of this thesis locate vocation within a person with mental illness' recovery journey. As detailed in Chapter Two, historically, the term vocation has been used to describe meaning and purpose in work and education domains, whereas this thesis takes a broader view that encompasses more than just paid work or employment. The person with mental illness is in the centre of the ecological model, which I have used as a theoretical tool at various points of the thesis. The person's unique understanding of the meanings of vocation and their personal vocational aspirations and experiences are located in this realm. This centredness echoes the person-centred orientation of the recovery model, as well as the person-occupation theoretical underpinnings of occupational therapy explained previously in Chapter Four.

The participants in Phase One of this study described vocation as a calling, encompassing meaningful, enjoyable, purposeful, and productive activity. These activities included paid and unpaid employment, education, training, work experience, and volunteering. In this phase of the study, there was a focus on obtaining paid work because participants described outcomes they wanted from vocation, such as making money, having financial security, socialising, and a sense of achievement. These were important components they felt would lead to work satisfaction. As described in Chapter Four, these intrinsic, social, extrinsic, and prestige work values (Elizur, 1984; Sagie et al., 1996) had led the participants to pursue paid employment as a vocation.

According to participants, with the onset of mental illness, came a severing from participation in usual occupations, which in turn lead to a loss of a sense of identity. Participants described the experience of being devalued, rejected, and isolated, which in turn led to wounding (Wolfensberger, 2000). They

internalised their personal experiences of social devaluation and stigmatisation, and gradually lost their previously held or desired identities. These previously held intrinsic understandings of themselves were replaced by the adoption and internalisation of stigmatised views of themselves (Van Brakel, 2006; Yanos et al., 2008). Engaging in vocational activity was a way of establishing or re-establishing oneself, and re-crafting one's identity. Service providers are uniquely positioned to be able to help people explore their personal work values as part of determining their vocational aspirations. In this way, a person may be better able to seek vocational environments that would support their specific values, as well as their interests and abilities. This person-centred focus of recovery in mental illness has been shown to promote better outcomes for consumers (Power, 2009).

In Phase Two, the rich descriptions of vocation from Phase One were further developed using a Delphi study. As stated in Chapter Five, there was consensus about the meaning of vocation and Delphi panellists agreed that:

> Vocation is a calling, where a person chooses to engage in purposeful, meaningful, enjoyable, and productive activity, and feels that the activity is what they are meant to do. The activity allows a person to be authentic or true to their own personality, spirit, or character. It is more than a job or career.

Although there was a fair amount of contention regarding *recovery* language, the consensus about the meaning of vocation was easily reached. This could have been because the concept of vocation is old and has links to theological, religious, and sociocultural perspectives. There was more clarity about work, and although all Delphi panellists did not define vocation as a calling, they agreed that employment, education, and volunteering were part of the broader and more meaningful definition.

In this phase of the study, Delphi panellists described personal benefits that vocation brought, which were closely aligned with the work values described above and in Chapter Four. Within the microsystem domain, mental health

services, vocational services, family, peers, and employers help support people in their vocational journeys. Therefore, these supports strengthen a person's ability to benefit from vocational activity. From a mesosystem perspective, interrelations between these supports were vital to the success of consumers in their vocational journeys. For example, Phase Three of the study highlighted the failure at the level of the mesosystem in supporting vocational recovery in mental illness. Although people with mental illness experienced complex vocational journeys that were often broken up by the episodic nature of their illness, service and systemic limitations added to the challenges they faced. The lack of connection between mental health and employment services and quasi-market conditions limited the implementation of person centred evidence-based services. Furthermore, lack of clear vocational pathways made planning and progressing on vocational journeys a difficult task for a vulnerable group.

7.2.2 Vocational recovery in mental illness in practice

The research has defined vocational recovery in mental illness through key stakeholder consensus and shown that the facilitators of a person's journey of vocational recovery in mental illness are closely aligned with those of the models of personal recovery that have been published (Andresen et al., 2003; Glover, 2012; Leamy et al., 2011) and were discussed in Chapters Two and Five. Central to these models were principles such as connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. Vocational activity is a way for people with mental illness to engage in recovery journeys. Vocational activity usually involves connecting with other people, and working towards and achieving vocational goals helps to build hope and optimism about the future. Vocation also enables the establishment or re-establishment of identity and helps people find meaning in life.

Research has shown that supporting people with mental illness with their individual career decisions can alleviate symptoms, contribute to hope and

self-esteem, and support the recovery process (Dolberg, 2012; Herr, 1989). Within systemic and societal contexts, people negotiate complex constraints of mental illness and may choose to engage with services for personal and vocational support. They may also turn to familial, peer, and social networks for this support. In doing so, they discover (or rediscover) their vocational recovery aspirations and goals. Staying connected and being engaged in life are central in promoting vocational recovery.

Dedicated mental health employment consultants who are person-centred in their approach are in ideal positions to facilitate positive vocational experiences for people with mental illness. The Delphi panellists in Phase Two and the key stakeholders in Phase Three were clear in describing the value and contribution service providers could make in being able to connect and develop positive relationships with people with mental illness. However, as discussed in Chapter Six, current policy does not support flexibility in service provision, which negatively impacts on the paths and services people with mental illness use in their vocational journeys. Further to this, vocation is not a priority for recovery services, and recovery is not a priority for vocational services. This situation undermines the notion of vocational recovery and whether it is put into practice. Subsequently, it has led me to question whether vocational recovery is an idealised concept, which without sufficient flexibility in service provision and adequate resourcing will not be realised for those who would most benefit from it. This contention is revisited later in this chapter.

7.2.3 Challenges people with mental illness experience in their vocational recovery journeys

The research identified significant barriers to vocational recovery in mental illness. Many of the elements that affected vocational recovery in mental illness were person-centred or service-oriented; however, policy, systemic, and societal factors also shaped the ways vocational recovery journeys occur. In Phase One of this study, the facilitators and barriers to vocation were explored,

which led to a more focussed investigation of the facilitators and barriers to vocational recovery in Phase Two. In Phase Three, the systemic and practice barriers to vocational recovery were investigated. The findings of this research were clear in recognising that the facilitators and barriers to vocational recovery in mental illness were dependent on the policies and structures that were in place to govern service provision. As discussed in the previous section, vocational recovery is an idealised notion, and the facilitators of this process are heavily dependent on person-centred, flexible, supportive, skilled, and experienced, service providers. In the current crisis-driven system, there is little funding for these facilitators, and they are far outweighed by barriers. Referring back to the Vocational Recovery in Mental Illness Model (Figure 7.1), the challenges consumers encounter in their vocational recovery journeys are presented from the person to practice, to the interactions between the microsystem components, to systemic, and environmental levels.

On an individual level, the challenges to vocational recovery included personal factors that were directly related to the experience of having mental illness, such as symptoms, side effects from medication, social devaluation, and wounding. Besides these, workplaces were considered difficult environments to negotiate due to feelings of anger, fear, and anxiety. Restrictions in vocational opportunities were described by participants who had lived experiences of mental illness. These negative experiences were compounded by frustrating processes regarding job seeking, such as having their personal preferences being dismissed by employment consultants and staff not understanding their individual experience of mental illness. Participants described strong feelings of anxiety in dealing with employment agencies and dispiriting experiences regarding disclosure of their mental illness.

At a microsystem level, service providers, employers, family members, and peers could be viewed as guides or companions on a person's vocational recovery journey. These guides and companions help in planning and mapping out vocational pathways, and when they are well integrated, they can be understood as a cohesive mesosystem of supports. An example of how the

mesosystem level can be better integrated in order to facilitate vocational recovery is the collocation of employment and mental health services. However, the complexity of the systemic policy and legislative context muddied what should be a clear process of connecting people with the supports they require. Besides a lack of person-centred support in services, other challenges at this level existed. There was little clarity about the vocational pathways that were available to people with mental illness. An added complexity for consumers is the conflicting philosophies that exist in vocational and recovery services, where the foci of services are mutually exclusive. For example in Chapter Four, I outlined the confusion people with mental illness experienced in terms of what employment supports were available to them.

Systemic issues such as constant change and lack of funding resulted in lost opportunities where innovative initiatives that had been developed by services to facilitate vocational recovery failed to be implemented. This was evident in the themes from the key informants in Phase Three where lack of funding resulted in unmet needs for consumers.

The policy and legislative context shapes pathways for vocational journeys and provides signposts for people with mental illness and service providers as navigational tools. Policy makers should enact progressive policies that encourage people with mental illness to be engaged in vocational activities. Systemic challenges to vocational recovery existed regarding workforce participation, rates of pay, transitional vocational preparation, and funding of vocational programs. Besides addressing these challenges, government policy-based strategies that promote vocational recovery for people with mental health issues include providing stronger incentives to work and support for education or training providers.

The environment, society, mass media, and the public shape a person's experiences whilst on their personal vocational recovery journey. At a macrosystem level, societal attitudes and ideologies of the culture contribute

to further stumbling blocks on people's vocational recovery journeys. Challenges such as stigma, prejudice, and discrimination taint a person's experience of vocational recovery. There have been considerable changes and developments in the care and support of people with mental illness over time, with the transition away from institutionalised care to models that promote and enable social inclusion and ordinary lives. Sociocultural conditions have gradually shifted so that we have a society that is more inclusive and supportive of people with mental illness. Nevertheless, participants in all phases of this study reported stigma and low expectations due to prejudiced views about people with mental illness. This stigma was a pervasive challenge to vocational recovery that existed in all levels of the ecological model.

7.2.4 Vocational recovery in Western Australia – rhetoric-reality gap

For the period of this study, there was an unmet need for services that facilitated vocational recovery in mental illness in Western Australia. In the previous chapter, vocational recovery was described in a case study of the local policy and service contexts. The policies of the Australian governments shape service provision and support for people with mental illness, and ultimately how they were able to actualise their vocational goals. However, there was a persistent conflict between the state of policy and the delivery of person-centred services that was financially driven. The most important performance criterion for funding DES were job placements and short-term tenure. Moreover, plurality of views on recovery in mental illness still existed. These tensions were reflected in the recovery language described in Chapter Five. Although there was consensus by Delphi panellists in almost all aspects of the Vocational Recovery in Mental Illness Model, disagreement still existed regarding specific elements of recovery. It was an important reflection of the separation between theoretical understandings of recovery in mental illness and current practice. A clear vision of the factors involved in the process of vocational recovery has been presented in Chapter Five. However, the participants in all three phases of this study confirmed that with regards to

vocation and recovery in mental illness, there were rhetoric-reality gaps where what was said to be done was not what was practised. This confirmed the contention that at the time this thesis was written, vocational recovery in mental illness was an idealised concept in the Western Australian context.

As discussed in Chapter Six of this thesis, there have been considerable changes in policies that affect vocational recovery in mental illness. Currently, Australia has, at national and state and territory levels, embedded recovery into policy and reform platforms. Although recovery and employment have been touted by policymakers as being high on the agenda, current policies, especially those regarding employment assistance for people with mental illness, would suggest otherwise. Competing tensions exist between cost-savings by governments and supporting person-centred vocational recovery. Increasingly, governments aim for efficiency and cost reduction in employment services. As such, there has been a strong movement towards contracting services to not-for profit and for profit organisations in a quasi-market system. This research has focussed on open employment in the competitive market and the DES system. Although there is a strong evidence base for IPS, there is little impetus for vocational services to develop fidelity with this model. This is due to their main order of business, which is to achieve the outcomes mandated by the policymakers, so as to obtain and maintain their funding base. These policymaker-mandated outcomes often do not complement consumers' vocational interests and aspirations.

7.2.5 Moving towards person-centred pathways to vocational recovery in mental illness

As discussed in Chapter Two, mental illness includes a broad range of conditions that vary in their nature and effect. In order to truly be recovery-focussed, policies must provide diverse employment pathways and encourage people with mental illness to explore different options in their vocational recovery journeys. Allowances should be made for services to be flexible in

supporting consumers in pursuing their personal vocational goals. Therefore, the provision of a diverse range of vocational arrangements and clear pathways to these are an area of need in the system. Besides paid employment, other pathways to vocational recovery exist. As discussed in Chapter One, these other vocational activities may include education, training, apprenticeships, volunteering, social enterprises, supported employment, and support through local community agencies and lay people. Exploration of these pathways are outside the scope of this thesis; however they are valid alternatives to mainstream employment support because they promote more gradual introductions or return to vocational activities for people who are not yet ready to work in open employment or people who experience symptoms that make it difficult to participate in mainstream employment on a permanent basis.

In order to support people with mental illness, it is important for DES providers to have knowledge about recovery in mental illness. Collocating mental health and employment expertise can facilitate vocational recovery. Vocation is a powerful vehicle in a person's recovery journey. Mental health and employment service providers should be mindful of the value meaningful and sustainable vocation can bring to a person's life.

7.3 Reflections on methods and the research process

"If the self is the lens through which we perceive the world, then it is crucial that the lens itself be included reflexively in any understanding of our world" (Fook, 1999, p. 17). In being intrinsically involved in the whole research process, I have brought my personal background, experiences, values, beliefs, and motivations to my research and writing. The interpretive methodology that I have used and which I explained in Chapter Three encouraged me to examine my own assumptions and to clarify how these impacted upon the findings of the study.

I approached the subject matter in this study with strong personal beliefs about mental illness, having grown up in a situation where my mother had periods of being very unwell with mental illness. However, we lived in an Asian society where stigma and shame meant that her illness remained hidden and was never spoken about. This experience and my choice of profession and training in occupational therapy theory offered a unique perspective as I was able to empathise with participants with lived experiences of mental illness. I was also able to use a critical lens to examine the flaws and disconnect between systemic, practice, and person levels of vocational recovery in mental illness.

In reflecting on the research process over the six years that this study took place, a general observation was that all the participants of three phases were open and insightful. They expressed passionate, yet balanced opinions about mental illness, vocational recovery, services, and national and local policy directions. These experiences supported the methodological choices made through the research process.

Engaging people with mental illness in the inclusive approaches used in Phase One reflected the vocational focus of the research. Focus group and research team members were valued collaborators in the research process, and they viewed their participation as a unique vocational experience where they could make a contribution. This approach provided an opportunity for knowledge from focus group and research team members who had lived experiences of mental illness to be shared and for me to learn from this process. This, in turn enriched the quality and of the research.

There were two significant changes that were made through the research process regarding the methods used. First, it was anticipated that in Phase One, people with lived experiences of mental illness would have different experiences and insights that were dependant on the stage of their vocational journeys. For example, a person who was in the early planning stages of seeking employment would have different experiences from a person who had

been employed for over six months. However, the themes in Phase One were unexpectedly uniform irrespective of the stage participants were in regarding obtaining employment. Participants who were seeking employment had similar experiences to those who were already employed. This, along with themes that emerged about recovery journeys led me to explore the notion of vocational recovery and the services that supported vocation. As such, the Delphi study was developed in Phase Two in order to explore these emerging themes from the first phase. Second, Phase Three was intended to provide an in-depth description of the application of the Framework for Facilitating Vocational Recovery in Mental Illness to local employment services using a multiple case study method. In order to do so, I had obtained in-principle support from four agencies that provided employment and training services for people with mental illness. However, during data collection, the government funded employment services that assisted people with disabilities in obtaining competitive employment in the open market underwent a tender process for new contracts. With the challenges and uncertainty the new service contracts brought, the agencies were not able to participate in Phase Three of the study. In consultation with my PhD supervisors, it was decided that the method of multiple case studies was not tenable in this climate of change. I decided to revise the methods to a single case study of how vocational recovery has been adopted by local services, the results of which were presented in Chapter Six. This change allowed me to examine vocational recovery in a case analysis of service provision in Western Australia, which has led to important findings in relation to policy and practices.

7.4 Limitations of the study

There were several limitations to this study, which must be considered when interpreting the findings. First, this research was specific to the context in which it was conducted. Western Australia, and specifically the Perth metropolitan area, demonstrated unique attributes due to the remoteness of the city and its relative economic prosperity. All participants resided in the

Perth metropolitan area and issues of cultural and linguistic diversity were not explored in any depth in this study. This means that caution should be exercised in transferring the findings nationally and internationally. As such, there are opportunities for further research into what vocational recovery means to people with mental illness from different cultural backgrounds and those living in different regions, including rural and remote areas.

The relatively small sample size in Phase One of the study raises questions as to the transferability of the results to people with mental illness more broadly. The consistency of the themes that emerged in this phase gave participants a strong and unified voice, which was of value in understanding the facilitators and barriers people with mental illness encounter in their vocational journeys. This limitation was also present in Phase Three, where a small number of key stakeholders were interviewed. These were necessary limitations due to time and resource restrictions of this PhD research. However, the "force of example" (Flyvbjerg, 2006, p. 228) of this single case study has contributed a good understanding of the issues faced by people with mental illness in their vocational recovery journeys. Due to the vast differences between Australian and overseas policies and practices with regards to employment for people with mental illness, it is important to be cautious in transferring findings to overseas contexts. Despite these limitations, the findings were strongly supported by theories on vocation and recovery in mental illness, and have contributed to understanding vocational recovery.

There may have been researcher bias in describing key informants' views and opinions in Phase Three. Although member checking (Lincoln & Guba, 1985) and a team approach to data analysis were performed in Phases One and Two, these strategies were not used in the final phase due to time limitations of the research process.

As the research was time-limited, a single case study was conducted in Phase Three in order to reduce the introduction of further stress for key informants, who already had high levels of work commitments. This could be improved by

conducting multiple descriptive case studies with employment and mental health service providers in order to have a greater understanding of vocational recovery approaches and practices.

7.5 Research Implications

Given the vocational support requirements of people with mental illness, coupled with the deficits in the actual delivery of employment services, the need for research becomes more vital. Due to low employment participation rates and the systemic and service challenges mentioned in this thesis, there is a need for further investigation into the effectiveness of services (microsystem) and the interactions between services (mesosystem). Further research is also needed to identify effective policies and practices for Western Australia. This study on vocational recovery focussed mainly on open employment in the competitive market and DES providers. Not all people with mental illness would choose open employment as a vocational goal. Therefore, exploring the diverse range of training, volunteering, and employment services would allow greater understanding of vocational recovery in these alternative settings. During this study, I encountered service providers who had been involved in discrete and novel approaches to vocational recovery. Examples of these were the *Voices at Work* project and the *Arts Pathway* project. These approaches also warranted investigation for their effects on vocational recovery in mental illness. Further research in these areas would contribute to the development of an understanding of clear pathways to vocational recovery.

The Framework for Facilitating Vocational Recovery in Mental Illness that was developed in this study may be further developed into a tool for vocational service providers who work with people with mental illness (provided in part in Appendix H). This tool may include vocational recovery processes that can guide consumers in their vocational choices. Research into the applicability and effectiveness of the Framework for Facilitating Vocational Recovery in

Mental Illness would be advantageous in verifying and modifying the framework to improve its usefulness in practice.

Further research into the fit between consumers' vocational choices and goals and placements through DES providers would provide insights into whether marginal employment options are being provided. An IPS project run by the Western Australian Association for Mental Health was in the preliminary stages of being implemented in the second half of 2013. Evaluations of the effectiveness of IPS in the Western Australian system using a partnership approach is needed to establish if the results in obtaining and keeping paid employment are comparable to national and international research outcomes.

7.6 Major Findings and Conclusion

Overall, this research has demonstrated that vocational recovery in mental illness holds deep personal meaning for consumers, and may be a pathway to a good life. This thesis has given insight into the lived experience of people with mental illness who have complex vocational journeys that are often severely disrupted through their illness. Vocational recovery, a previously poorly understood concept, has been defined through key stakeholder consensus in this research. Further to this, the concept of vocational recovery has been described and discussed through the application of an ecological approach that allows the reader to appreciate the fundamental centrality of the person and how they are affected by their illness. The ecological approach also presented the degree to which people with mental illness have agency in relation to people within their network, organisation, and within a broader socio-political, economic, and cultural environment. A framework was developed that details the facilitators for vocational recovery at all levels of the ecological model. This Framework for Facilitating Vocational Recovery in Mental Illness contributes to the theoretical understanding of the meaning and value of vocational recovery that is far more aligned with recovery principles than previous definitions. This framework may be useful to mental

health consumers, as well as various service providers and policy makers who support them in their vocational recovery journeys. The practicality of the Framework for Facilitating Vocational Recovery in Mental Illness was tested through discussion with key informants in Western Australia, and significant barriers to the application of the framework were identified.

In order to best support vocational recovery in mental illness, consumers should be central to policy-making and service provision. The main challenge is how person-centred services are implemented in an environment where policy and services are ever changing and increasingly financially-driven. Currently, mainstream employment services operate under a quasi-market system that promotes cost-saving formulaic approaches, poorly skilled staff, and efficiency and effectiveness measures that fulfil funding contract quotas. This lack of flexible person-centred and recovery practices has led to marginal employment placements and risk selection where people with mental illness are turned away from services in favour of more lucrative clients. In order to truly support people with mental illness, their personal choice and control of their vocational recovery journeys should be respected in practice. Services should be delivered in a way that affirms the rights of people with mental illness as active and contributing members of society. Access to clear vocational pathways for a vulnerable and marginalised group, such as people with mental illness, is a matter of social and occupational justice.

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Appendix A: Section of Combined Intellectual and Physical Research Audit Trail

An intellectual research audit trail was used as a tool for me to reflect on how my thinking evolved through the course of this six-year long multi-method qualitative research project. A physical audit trail was used to document the three main phases of this research study, as well as the key research methodological decisions that were made. The combined research audit trail for the three phases of this study is represented below:

Starting philosophical position: In the early stages of developing my study proposal, my research philosophy was largely positivist, due to previous research experiences that involved hypothesis testing, statistical data analysis, and systematic reviews.

Finding a philosophical stance: In early discussions with one of my PhD supervisors, I became aware of the limitations of positivist research in terms of simplistic representation of the real world, which would be restrictive in addressing this study's research questions. The exploratory nature of this research lent itself much more to a philosophical stance that allowed in-depth understandings of the complex issues surrounding vocation for people with mental illness. Through supervisory guidance and from reviewing qualitative research methodology literature, I arrived at the view that an interpretivist perspective would be appropriate starting point. This position allowed holistic capture of contextual depth, which incorporated an understanding of participants' worlds through their values and voices.

Identification of the research problem: Upon enrolment into the PhD program in 2007, I met on a number of occasions with one of my PhD supervisors and Ruah Workright (a specialist mental health employment service who provided scholarship funding for my study) managers and key personnel to discuss suitable areas of study within the sector that provides employment services for people with mental illness. The service had just

undergone an evaluation of its employment program using the Supported Employment Fidelity Scale (Cocks and Boaden, 2009). Although the management of the partner organisation was keen to implement an intervention study to improve its fidelity with the IPS model, uncertainty regarding ongoing funding arrangements in an election year made this type of project problematic. Through discussion with one of my supervisors, I decided to explore vocation more broadly.

Development of the research proposal: A research proposal was developed and presented to the School of Occupational Therapy's academic staff. Staff and research students had the opportunity to raise questions and make comment on the research and the methods proposed in this forum. Subsequently, the proposal was submitted to Curtin University's Faculty of Health Science Graduate Studies Committee for approval. The proposal included a background to the research, an outline of the study, its aims and objectives, the research questions, significance of the research, a description of the methods, and details of ethical considerations. The proposal was also submitted to Curtin University's Human Research Ethics Committee, the Western Australian Health Department's South Metropolitan Human Research Ethics Committee, and Ruah Workright who funded the scholarship for this research. Approval was obtained from all parties in 2008.

Appendix B: Phase One Information Sheets and Consent Forms

Curtin
University of Technology

Invitation to Participate

I am seeking people diagnosed with a mental health disorder to participate in a research project:

Vocational Journeys of People with Mental Illness

This research aims to explore people's experiences of negotiating services and pathways towards achieving their goals in terms of learning, work, volunteering or contribution within the community.

If you are interested in participating in this project, please get an information sheet from <insert organisation's contact person> or myself. Alternatively, you can register your interest by calling me on the number below or through <insert organisation's contact person>.

If you would like to talk more about this project, please do not hesitate in contacting me.

Julie Netto

PhD Candidate

9266 3745

Curtin University of Technology

School of Occupational Therapy

Participant Information Sheet – Consumer Reference Group

Vocational Journeys of People with Mental Illness

My name is Julie Netto. I am currently completing research for my doctorate at Curtin University of Technology.

Purpose of Research

I am investigating how people with mental illness establish and achieve their goals in terms of learning, work, volunteering or contribution within the community.

Outline of Research

The project has three stages:-

1. A Consumer Reference Group of people with mental illness who are engaged in vocational activity will be established to develop and pilot an interview guide that explores vocational aspirations and pathways.

2. Three groups of people with mental illness at different stages in their vocational journeys will participate in interviews and focus groups over 18 months to map pathways and identify facilitators and barriers to the achievement of their vocational aspirations.

3. Some participants and the Consumer Reference Group members will develop a publication that describes pathways to assist people with mental illness negotiate vocational services. Further to this, a workshop will be run to provide a forum for participants and vocational service providers on what has been learned from the project and to plan for possible further activity.

Your Role

I am interested in your participation in a consumer reference group to develop an interview guide for finding out about work, training or volunteering experiences and what services and supports people with mental illness have found helpful or unhelpful. Participation will include a series of up to three focus groups with me and other consumer reference group members at a suitable place. The groups will be held over a period of one month, in May and June 2008. Each focus group will take approximately 120 minutes. You will receive a payment of $30 for your time at the end of each group session.

You may choose to be involved in stage two of the project either as a participant or in assisting in validating the research data. You may also elect to be involved in stage three of the project – being involved in developing a publication that describes pathways to assist people with mental illness negotiate vocational services, and/or assisting in running a collaborative workshop to inform service providers of the perspectives of participants regarding vocational journeys and outcomes.

Consent to Participate

Your involvement in the research is entirely voluntary. You have the right to withdraw at any stage without affecting your rights or use of services. When you have signed the consent form, I will assume that you have agreed to participate and allow me to use your data in this research.

Confidentiality

The information you provide will be kept separate from your personal details, and only I will have access to this. The group transcripts will not have your name or other identifying information on it and in adherence to university policy, all data will be kept in a locked cabinet for seven years, before it is destroyed. Your privacy is greatly respected

Further Information

If you would like further information about this study, please feel free to contact me on 9266 3745 or by email: J.Netto@curtin.edu.au. Alternately, you can contact my supervisor Professor Errol Cocks on 9266 3659 or E.Cocks@curtin.edu.au.

Thank you very much for your involvement in this research. Your participation is greatly appreciated.

This research has been reviewed and given approval by the Curtin University of Technology Human Research Ethics Committee (approval number HR166/2007). Should you wish to make a complaint on ethical grounds, please contact the Human Ethics Committee (Secretary), phone: 9266 2784, email: hrec@curtin.edu.au, mail: C/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth WA 6845

Personal consent to participate in research –

Consumer Reference Group

Vocational Journeys of People with Mental Illness

Aims of this research

The aim of this research is to explore with people who have been diagnosed with a mental illness, their experiences of negotiating services in order to establish and achieve vocational goals.

Participation

Participation is voluntary and will not affect services you receive.

Participation can be withdrawn at any stage of the research process and there is no consequence for withdrawal.

Confidentiality

All personal information will remain confidential and no one will be identifiable in either the research workings or publications.

Any identifying information will be stored in a secure cabinet with researcher access only.

People who choose to participate can access their information at any time via the researcher.

Nominated mental health practitioner contact

In an event that you are unwell and unable to actively participate in parts of the research, who would you prefer us to contact?

Name & position:

Contact number:

I, the undersigned, have been presented with information about this research that I have understood and I agree to participate according to these terms.

Name: _____

Signature: _____

Date: _____

Curtin University of Technology

School of Occupational Therapy

Participant Information Sheet

Vocational Journeys of People with Mental Illness

My name is Julie Netto. I am currently completing research for my doctorate at Curtin University of Technology.

Purpose of Research

I am investigating how people with mental illness establish and achieve their goals in terms of learning, work, volunteering or contribution within the community.

Your Role

I am interested in finding out about your work, training or volunteering experiences and what services and supports you have found helpful or unhelpful. Participation will include a series of four interviews with me at a suitable place, along with follow-up focus groups with other participants to clarify themes from the interviews and provide feedback.

The interviews and focus groups will be held over a period of 18 months, from February 2008 – July 2009. Each interview and focus group will take approximately 60 minutes and will be taped and transcribed. You will receive a payment of $20 for your time.

The interviews will provide information on your individual vocational journey and identify barriers and facilitators you experience at various stages of the process. These insights will be used to develop a publication that describes pathways to assist people with mental illness negotiate vocational services. Further to this, a workshop will be run to provide a forum for participants and vocational service providers on what has been learned from the project and to plan for possible further activity.

The findings of the research will be published in scholarly journals and in my thesis.

Consent to Participate

Your involvement in the research is entirely voluntary. You have the right to withdraw at any stage without affecting your rights or use of services. When you have signed the consent form, I will assume that you have agreed to participate and allow me to use your data in this research.

Confidentiality

The information you provide will be kept separate from your personal details, and only I will have access to this. The interview transcripts will not have your name or other identifying information on it and in adherence to

university policy, all data will be kept in a locked cabinet for seven years, before it is destroyed. Your privacy is greatly respected

Further Information

If you would like further information about this study, please feel free to contact me on 9266 3745 or by email: J.Netto@curtin.edu.au. Alternately, you can contact my supervisor Professor Errol Cocks on 9266 3659 or E.Cocks@curtin.edu.au.

Thank you very much for your involvement in this research. Your participation is greatly appreciated.

This research has been reviewed and given approval by the Curtin University of Technology Human Research Ethics Committee (approval number HR166/2007). Should you wish to make a complaint on ethical grounds, please contact the Human Ethics Committee (Secretary), phone: 9266 2784, email: hrec@curtin.edu.au, mail: C/- Office of Research and Development, Curtin University of Technology, GPO Box U1987, Perth WA 6845

Curtin University of Technology

Personal consent to participate in research

Vocational Journeys of People with Mental Illness

Aims of this research

The aim of this research is to explore with people who have been diagnosed with a mental illness, their experiences of negotiating services in order to establish and achieve vocational goals.

Participation

Participation is voluntary and will not affect services you receive.

Participation can be withdrawn at any stage of the research process and there is no consequence for withdrawal.

Confidentiality

All personal information will remain confidential and no one will be identifiable in either the research workings or publications.

Any identifying information will be stored in a secure cabinet with researcher access only.

People who choose to participate can access their information at any time via the researcher.

I, the undersigned, have been presented with information about this research that I have understood and I agree to participate according to these terms.

Name: _____

Signature: _____

Date: _____

Appendix C: Phase Two Consent Forms

Personal consent to participate in research

Vocational Recovery of People with Mental Illness

I consent to participate in this research project. The nature of the research has been explained to me to my satisfaction and all of my questions answered. I understand that I am free to withdraw from the study at any time without any consequences.

I understand that a survey will be conducted in three rounds. In the first round, I will be asked to address broad questions including my concept and definition of vocational recovery, as well as comment on definitions from earlier stages of the research project. The outcomes will form the next two rounds' questions aiming for more clarity to further develop the definition. This information will be used to develop the framework.

I understand that I will be asked to complete a questionnaire in each round and to return the completed questionnaires to the researcher within one week. If required, I may be contacted after a two week period to confirm return of the completed questionnaire.

I agree that results of this study may be published and, if so, my identity will be protected.

Name: _____ Date: _____

Signature: _____ Email: _____

Researcher: Julie Netto

Tel: (08) 9266 3625

Email: J.Netto@curtin.edu.au

Project Supervisor: Professor Errol Cocks

Tel: (08) 9266 3621

Email E.Cocks@curtin.edu.au

Appendix D: Delphi Themes from Round One Sent to Panellists for Comment

Q1: How may vocation be described?

Vocation is described in two ways:

1. Vocation is a calling, where a person chooses to engage in purposeful, meaningful, and productive activity, or feels that the activity is what they are meant to do. The activity allows a person to be authentic or true to one's own personality, spirit, or character. It is more than a job or career.

2. Vocation is an activity based on choice that brings about personal benefits, such as:
    - Financial rewards;
    - Fulfilment from achieving work goals and career development;
    - Adoption of meaningful roles, such as being a team member and a workmate;
    - Personal growth and development, including improved self-esteem, confidence, a sense of purpose, an ability to meet challenges, and creative expression;
    - Relationships with other people;
    - Stability in one's life; and
    - Satisfaction from contributing to society.

Q2: How is recovery described for people with mental illness?

1. Recovery means: Personal insight into mental illness and management of symptoms, which includes:
    - An acceptance of mental illness and oneself; and
    - An ability to self-manage, including getting plenty of rest, anticipating likely problems, doing regular exercise, being compliant to a medical regime, monitoring illness, having strategies in dealing with fears of past experiences, and active coping.

2. Engagement in meaningful occupations based on interests and preferences and having balance in work, rest, and play.

3. Hope and optimism for the future and a good life.

In order to recover, personal and external factors are needed.

1. Personal capacities and beliefs that allow a person to set personal goals and engage in activities include:
    - Self-belief and a sense of purpose;
    - Empowerment and motivation to change;
    - Confidence in one's own identity;
    - Self-determination; and
    - Being contented.

2. External supports include:
    - A familial, peer, and social support network that:
        - Fosters personal contact and community inclusiveness; and
        - Is available, accessible, appropriate, inclusive, and flexible.
    - Health professionals who support access to early intervention, provide effective diagnoses and clinical intervention, and assist in developing strategies to overcome barriers to recovery;
    - Structural resources that support personal capacities, such as:
        - Stable accommodation and having basic needs met (food, shelter, and warmth);
        - Routine and structure to life; and
        - An income.

Q3: What are the facilitators of vocational recovery?

1. Paid work allows individuals to have money for basic things and financial stability.

2. Acknowledgement of each individual's capacity and choice, so that individuals may participate in their chosen area of interest.
3. Support for education and skill development, early on-the-job training, and access to information about vocational recovery.
4. Supportive vocational environments that recognise mental illness as an illness, free from stigma.
5. Making a contribution and being a citizen allows an individual to be part of a team and participate and be included in society.

Q4: What challenges to vocational recovery do people face?

1. Individuals face personal challenges with regards to:
    - Symptom management and side effects from medication, adjustment to changes in medication, and genuine limitations on performance due to symptoms;
    - Dealing with mental health issues specific to returning to the workforce such as social anxiety, fear of change, apprehension about relapse, and lack of motivation;
    - Disempowerment, loss of hope, loss of confidence, and loss of identity and purpose; and
    - Gaps employment history and lack of current skills, qualifications, or recent experience.

2. Social and interpersonal challenges to vocational recovery may include:
    - Stigma, discrimination, and prejudice influence an individual's decision to disclose. Low expectations from service providers, the community, and employers are demotivating elements that promote the sick role;
    - Restricted social networks may limit vocational opportunities;
    - Lack of mentoring and support; and
    - Lack of flexibility of prospective employers and workplaces.

3. The mental health system, policies, and service provision also pose challenges, such as:

- Limitations in the current employment policy regarding open employment, rates of pay, and funding to vocational programs;
- A lack of mutual obligation – growth comes from challenges and responsibility;
- Reduced flexibility in vocational opportunities and service response to changing needs;
- Employment assessments not based on personal strengths;
- Inconsistent clinical support;
- Expensive training programs; and
- Financial disincentives to work due to the disability support pension.

Q5: What activities promote vocational recovery for people with mental health issues?

1. Personal activities that involve staying connected and being engaged in life. These include:
   - Keeping well by eating good food, having a routine, exercising and being active, and being able to self-manage mental illness;
   - Having balance in life by engaging in meaningful work and leisure activities;
   - Learning life skills that support vocation such as: time and money management, taking transportation, communication skills, and building confidence and self-esteem;
   - Being committed to short-, medium-, and long-term personal goals; and
   - Participation in social activities that promote relationships with peers.

2. Service-based activities include:
   - Person-centred programs that focus on training, education, work experience, and supported employment. Creating a space to grow involves engagement by people delivering services, early identification of vocational goals, small steps in training, and a gradual return-to-work;

- Early intervention programs with strategies for long term self-management of illness, team support from a range of professionals including psychiatrists, psychologists, occupational therapists, vocational advisors, and peer support workers; and
- Access to specialised disability employment services that work in close partnership with clinical services to provide programs for skill development and rapid job search.

3. Government policy-based strategies include:
    - Providing stronger incentives to work; and
    - Support for education or training providers.

Q6: How can services encourage vocational recovery for people with mental health issues?

1. Service providers can encourage vocational recovery by:
    - Being attentive, responsive, flexible, encouraging, and understanding in providing individualised support;
    - Acknowledging individuals' existing skills and history, and focusing on their strengths, capacities, abilities, and potential;
    - Acknowledging individuals as experts in their own recovery;
    - Empowering individuals to make informed decisions and take responsibility for them;
    - Creating opportunities with vocation as a central goal of recovery; and
    - Providing evidence of successful role models.

2. Influencing employers and the community by raising awareness and engagement, and advocating for people with mental health issues.

3. Facilitating strong partnerships, such as including disability employment services within the mental health teams and building relationships between service providers and employers.

4. Remaining open to new and novel forms of employment or volunteering.

Appendix E: Delphi Themes from Round Two Sent to Panellists for Comment

The following document has condensed the responses from all the participants. I have removed a small number of outlying responses, as well as draft responses that were seen as unacceptable by the majority of the participants. I've made changes in terminology where feedback from participants was given. I have included different contested ideas in the framework as a point of discussion, and I hope to have follow-up interviews with recovery advocates in the group to uncover what is underpinning the recovery movement. Although some views may not be shared by all, different responses from all the stakeholders involved in this survey reflect the varied ideas that exist in the mental health system.

Q1: How may vocation be described?

1. Vocation is a calling, where a person chooses to engage in purposeful, meaningful, enjoyable, and productive activity, and feels that the activity is what they are meant to do. The activity allows a person to be authentic or true to their own personality, spirit, or character. It is more than a job or career.

2. A job or career may be part of vocation, and are based on choice that brings about personal benefits, such as:
    - Financial rewards;
    - Fulfilment from achieving work goals and career development;
    - Adoption of meaningful roles, such as being a team member and a workmate;
    - Identifying oneself as part of a group in terms of trade or profession;
    - Personal growth and development, including improved self-esteem, confidence, a sense of purpose, an ability to meet challenges, and creative expression;
    - Relationships with others;
    - Stability in the person's life; and

- Satisfaction from having a place in, and contributing to society.

Q2: How is recovery from mental illness understood?

1. "A personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life." (Mental Health Commission, Government of Western Australia ,2010 Mental Health 2020)

2. "Recovery is the process of regaining active control over one's life. This may involve discovering (rediscovering) a positive sense of self, accepting and coping with reality of any ongoing distress or disability, finding meaning in one's experiences, resolving personal, social or relationship issues that may contribute to one's mental health difficulties, taking on satisfying and meaningful social roles, and calling on formal and/or informal systems of support as needed. Services can be important aspects of recovery but the extent of the need for services will vary from one person to another." (Social Care Institute for Excellence, 2007. A common purpose: Recovery in future mental health services Joint Position Paper 08)

3. Recovery is described and directed by the person, and is intended to create a space for hope and positive growth.

4. Being optimistic about the future and a good life.

5. Recovery involves having a personal understanding of mental illness within a person's life, which includes:
   - An acceptance of mental illness and oneself; and
   - Actions undertaken by the person to cope with the impacts of their condition. Examples of this may include: getting plenty of rest, anticipating likely problems, doing regular exercise, regularly taking medication, monitoring illness, having strategies in dealing with fears of past experiences, and active coping.

6. Engagement in meaningful occupations based on interests and preferences and having life balance.

Personal and external factors are elements of individuals' recovery journeys.

1. Personal capacities that allow a person to set personal goals and engage in activities include having:
    - Self-belief and a sense of purpose;
    - A sense of empowerment and motivation to change;
    - Confidence in one's own identity;
    - An ability to self-determine;
    - Active coping strategies (for example through shared decision making or autonomy in life choices);
    - Healthy habits that maintain a person's wellbeing;
    - An ability to identify what is and what is not within one's control and being able to set priorities from this; and
    - A sense of contentment.

2. External supports include:
    - A familial, peer, and social support network that:
        - Fosters personal contact and community inclusiveness; and
        - Is available, accessible, appropriate, inclusive, and flexible.
    - Connections with professionals in safe places conducive to personal growth within or outside of the mental health system;
    - Structural resources that support personal capacities, such as:
        - Stable accommodation and having basic needs met (food, shelter, and warmth);
        - Routine and structure to life; and
        - An income.

Q3: What challenges to vocational recovery do people face?

1. Individuals face personal challenges with regards to:
    - Symptoms, side effects from medication, adjustment to changes in medication, and genuine limitations on performance due to reactions and experiences;
    - Dealing with mental health issues specific to returning to the workforce such as social anxiety, fear of change, and lack of motivation;
    - Social devaluation and wounding leading to disempowerment, loss of hope, loss of confidence, loss of identity and purpose, and self-stigma; and
    - Gaps in employment history and lack of current skills, qualifications, or recent experience.

2. Social and interpersonal challenges to vocational recovery may include:
    - Oppression due to stigma, discrimination, prejudice, and narrow framings of mental illness may influence an individual's decision to disclose. Low expectations from service providers, the community, and employers are demotivating elements that promote the sick role;
    - Restricted social networks may limit vocational opportunities;
    - A lack of mentoring and support;
    - Poor understanding of mental illness by society, friends, and family; and
    - A lack of flexibility of prospective employers and workplaces.

3. The mental health system, policies, and service provision also pose challenges, such as:
    - Limitations in the current employment policy regarding open employment, rates of pay, and funding provided for vocational programs;
    - A lack of transitional vocational preparation programs that focus on work skills that may have been lost or fractured through long-term unemployment;

- A lack of mutual obligation – growth comes from challenges and responsibility;
- Reduced flexibility in vocational opportunities and service response to changing needs (e.g. periodic nature of illness);
- Employment assessments not based on personal strengths;
- Inconsistent clinical support;
- A lack of access to personal recovery focussed education;
- Inadequate access to alternative supports;
- Expensive training programmes; and
- Financial disincentives to work due to the disability support pension.

Q4: What are the facilitators of vocational recovery?

1. Paid work allows individuals to have money for basic things and financial stability.
2. Service providers' acknowledgement of each individual's capacity and choice, so that individuals may participate in their chosen area of interest.
3. Support for education and skill development, early on-the-job training, and access to information about vocational recovery.
4. Transitional and vocational programs that deliver outcomes in a safe and supported environment in order to foster the development of resilience to navigate, manage, and cope in the mainstream workplace.
5. Supportive and inclusive vocational environments, which are free from stigma.

Q5: What activities promote vocational recovery for people with mental health issues?

1. Personal activities that involve staying connected and being engaged in life. These include:
    - Keeping well by eating healthily, having a routine, exercising, and being active;
    - Having balance in life by engaging in meaningful work and leisure activities;

- Learning specific life skills to support vocation such as: time and money management, taking transportation, communication skills, and building confidence and self-esteem;
- Being committed to short-, medium-, and long-term personal goals;
- Participation in community-based social activities that promote relationships with peers; and
- Making a contribution and being a valued member of society.

2. Service-based activities include:
    - Person-centred programs that focus on training, education, work experience, and supported employment. Creating a space to grow involves engagement by people delivering services, early identification of vocational goals, small steps in training, and a gradual return-to-work;
    - Early intervention programs with strategies for long term self-management of illness, team support from a range of professionals including psychiatrists, psychologists, occupational therapists, vocational advisors, and peer support workers;
    - Transitional services that focus on training and guidance that will contribute directly to a person's ability to obtain employment and establish and maintain independence; and
    - Access to specialised disability employment services that work in close partnership with clinical services to provide programmes for skill development and rapid job search.

3. Government policy-based strategies include:
    - Providing stronger incentives to work; and
    - Support for education or training providers.

Q6: How can services encourage vocational recovery for people with mental health issues?

1. Service providers can encourage vocational recovery by:

- Being attentive, responsive, flexible, encouraging, and understanding in providing individualised support;
- Acknowledging individuals' existing skills and history, and focussing on their strengths, capacities, abilities, and potential;
- Recognizing individuals as having knowledge of their own recovery from direct experience;
- Supporting individuals to make informed decisions and take responsibility for them;
- Creating opportunities with vocation as a central goal of recovery; and
- Providing evidence of successful role models.

2. Influencing employers and the community by raising awareness and improving engagement, and advocating for people with mental health issues, as well as supporting them in advocating for themselves in order to foster more consumer driven and operated services.

3. Facilitating strong partnerships, such as including disability employment services, vocational rehabilitation services, and housing services within the mental health teams and building relationships between service providers and employers.

4. Remaining open to new and novel forms of employment or volunteering.

Appendix F: Final Document with Delphi Themes

Vocation

1. Vocation is a calling, where a person chooses to engage in purposeful, meaningful, enjoyable, and productive activity, and feels that the activity is what they are meant to do. The activity allows a person to be authentic or true to their own personality, spirit, or character. It is more than a job or career.

2. A job or career may be part of vocation, and are based on choice that brings about personal benefits, such as:

    - Financial rewards;
    - Fulfilment from achieving work goals and career development;
    - Adoption of meaningful roles, such as being a team member and a workmate;
    - Identifying oneself as part of a group in terms of trade or profession;
    - Personal growth and development, including improved self-esteem, confidence, a sense of purpose, an ability to meet challenges, and creative expression;
    - Relationships with others;
    - Stability in the person's life; and
    - Satisfaction from having a place in, and contributing to society.

Recovery in mental illness

1. "A personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life." (Mental Health Commission, Government of

Western Australia ,2010 Mental Health 2020)

2. "Recovery is the process of regaining active control over one's life. This may involve discovering (rediscovering) a positive sense of self, accepting and coping with reality of any ongoing distress or disability, finding meaning in one's experiences, resolving personal, social or relationship issues that may contribute to one's mental health difficulties, taking on satisfying and meaningful social roles, and calling on formal and/or informal systems of support as needed. Services can be important aspects of recovery but the extent of the need for services will vary from one person to another." (Social Care Institute for Excellence, 2007. A common purpose: Recovery in future mental health services Joint Position Paper 08)

3. Recovery is described and directed by the person, and is intended to create a space for hope and positive growth.

4. Being optimistic about the future and a good life.

5. Recovery involves having a personal understanding of mental illness within a person's life, which includes:

    - An acceptance of mental illness and oneself; and

    - Actions undertaken by the person to cope with the impacts of their condition. Examples of this may include: getting plenty of rest, anticipating likely problems, doing regular exercise, regularly taking medication, monitoring illness, having strategies in dealing with fears of past experiences, and active coping.

6. Engagement in meaningful occupations based on interests and preferences and having life balance.

Personal and external factors are elements of individuals' recovery journeys.

1. Personal capacities that allow a person to set personal goals and engage

in activities include having:

- Self-belief and a sense of purpose;
- A sense of empowerment and motivation to change;
- Confidence in one's own identity;
- An ability to self-determine;
- Active coping strategies (for example through shared decision making or autonomy in life choices);
- Healthy habits that maintain a person's wellbeing;
- An ability to identify what is and what is not within one's control and being able to set priorities from this; and
- A sense of contentment.

2. External supports include:

- A familial, peer, and social support network that:
    - Fosters personal contact and community inclusiveness; and
    - Is available, accessible, appropriate, inclusive, and flexible.
- Connections with professionals in safe places conducive to personal growth within or outside of the mental health system;
- Structural resources that support personal capacities, such as:
    - Stable accommodation and having basic needs met (food, shelter, and warmth);
    - Routine and structure to life; and
    - An income.

Challenges to vocational recovery

1. Individuals face personal challenges with regards to:
    - Symptoms, side effects from medication, adjustment to changes in medication, and genuine limitations on performance due to reactions and experiences;
    - Dealing with mental health issues specific to returning to the workforce such as social anxiety, fear of change, and lack of motivation;
    - Social devaluation and wounding leading to disempowerment, loss of hope, loss of confidence, loss of identity and purpose, and self-stigma; and
    - Gaps in employment history and lack of current skills, qualifications, or recent experience.
2. Social and interpersonal challenges to vocational recovery may include:
    - Oppression due to stigma, discrimination, prejudice, and narrow framings of mental illness may influence an individual's decision to disclose. Low expectations from service providers, the community, and employers are demotivating elements that promote the sick role;
    - Restricted social networks may limit vocational opportunities;
    - A lack of mentoring and support;
    - Poor understanding of mental illness by society, friends, and family; and
    - A lack of flexibility of prospective employers and workplaces.
3. The mental health system, policies, and service provision also pose challenges, such as:
    - Limitations in the current employment policy regarding open

employment, rates of pay, and funding provided for vocational programs;

- A lack of transitional vocational preparation programs that focus on work skills that may have been lost or fractured through long-term unemployment;
- A lack of mutual obligation – growth comes from challenges and responsibility;
- Reduced flexibility in vocational opportunities and service response to changing needs (e.g. periodic nature of illness);
- Employment assessments not based on personal strengths;
- Inconsistent clinical support;
- A lack of access to personal recovery focussed education;
- Inadequate access to alternative supports;
- Expensive training programs; and
- Financial disincentives to work due to the disability support pension.

Facilitators of vocational recovery

1. Paid work allows individuals to have money for basic things and financial stability.
2. Service providers' acknowledgement of each individual's capacity and choice, so that individuals may participate in their chosen area of interest.
3. Support for education and skill development, early on-the-job training, and access to information about vocational recovery.
4. Transitional and vocational programs that deliver outcomes in a safe

and supported environment in order to foster the development of resilience to navigate, manage, and cope in the mainstream workplace.

5. Supportive and inclusive vocational environments, which are free from stigma.

Activities that promote vocational recovery

1. Personal activities that involve staying connected and being engaged in life. These include:

    - Keeping well by eating healthily, having a routine, exercising, and being active;
    - Having balance in life by engaging in meaningful work and leisure activities;
    - Learning specific life skills to support vocation such as: time and money management, taking transportation, communication skills, and building confidence and self-esteem;
    - Being committed to short-, medium-, and long-term personal goals;
    - Participation in community-based social activities that promote relationships with peers; and
    - Making a contribution and being a valued member of society.

2. Service-based activities include:

- Person-centred programs that focus on training, education, work experience, and supported employment. Creating a space to grow involves engagement by people delivering services, early identification of vocational goals, small steps in training, and a gradual return-to-work;
- Early intervention programs with strategies for long term self-

management of illness, team support from a range of professionals including psychiatrists, psychologists, occupational therapists, vocational advisors, and peer support workers;

- Transitional services that focus on training and guidance that will contribute directly to a person's ability to obtain employment and establish and maintain independence; and
- Access to specialised disability employment services that work in close partnership with clinical services to provide programs for skill development and rapid job search.
- Government policy-based strategies include:
- Providing stronger incentives to work; and
- Support for education or training providers.

How services encourage vocational recovery

1. Service providers can encourage vocational recovery by:

- Being attentive, responsive, flexible, encouraging, and understanding in providing individualised support;
- Acknowledging individuals' existing skills and history, and focussing on their strengths, capacities, abilities, and potential;
- Recognizing individuals as having knowledge of their own recovery from direct experience;
- Supporting individuals to make informed decisions and take responsibility for them;
- Creating opportunities with vocation as a central goal of recovery; and
- Providing evidence of successful role models.

2. Influencing employers and the community by raising awareness and improving engagement, and advocating for people with mental health issues, as well as supporting them in advocating for themselves in order to foster more consumer driven and operated services.

3. Facilitating strong partnerships, such as including disability employment services, vocational rehabilitation services, and housing services within the mental health teams and building relationships between service providers and employers.

4. Remaining open to new and novel forms of employment or volunteering.

Appendix G: Phase Three Consent Forms and Information Sent to Key Informants

Personal consent to participate in research

Vocational Recovery of People with Mental Illness

Aims of this research

The aim of this research is to describe vocational recovery in the Western Australian context.

Participation

Participation is voluntary, and may be withdrawn at any stage of the research process and there is no consequence for withdrawal.

Confidentiality

All personal information will remain confidential and no one will be identifiable in either the research workings or publications.

Any identifying information will be stored in a secure cabinet with researcher access only.

People who choose to participate can access their information at any time via the researcher.

I, the undersigned, have been presented with information about this research that I have understood and I agree to participate according to these terms.

Name: _____

Signature: _____

Date: _____

This research has been reviewed and given approval by the Curtin University Human Research Ethics Committee (approval number HR58/2011). Should you wish to make a complaint on ethical grounds, please contact the Human Ethics Committee (Secretary), phone: 9266 2784, email: hrec@curtin.edu.au, mail: C/- Office of Research and Development, Curtin University, GPO Box U1987, Perth WA 6845

Vocational Recovery of People with Mental Illness

The aim of this survey is to explore how vocational recovery is encouraged and facilitated in the Perth mental health system and the programs within it. Additionally, I am interested in your thoughts on how recent changes to your services have impacted service users' experience of vocational recovery.

Please read the following summary from the draft Framework for Facilitating Vocational Recovery in Mental Illness document I have developed with the input from key stakeholders (such as service users, service providers, policy makers, academics, advocates and family members) and answer the questions on the following page.

Vocation is described as a calling, where a person chooses to engage in purposeful, meaningful, enjoyable, and productive activity, and feels that the activity is what they are meant to do. The activity allows a person to be authentic or true to their own personality, spirit, or character. It is more than a job or career. Vocational recovery involves regaining or establishing a range of valued roles associated with vocation as broadly defined in the preceding sentences.

Activities that promote vocational recovery for people with mental health issues include:

1. Personal activities that involve staying connected and being engaged in life. These include:

- Keeping well by eating healthily, having a routine, exercising, and being active;
- Having balance in life by engaging in meaningful work and leisure activities;
- Learning specific life skills to support vocation such as: time and money management, taking transportation, communication skills, and building confidence and self-esteem;
- Being committed to short-, medium-, and long-term personal goals;

- Participation in community-based social activities that promote relationships with peers; and
- Making a contribution and being a valued member of society.

2. Service-based activities include:

- Person-centred programs that focus on training, education, work experience, and supported employment. Creating a space to grow involves engagement by people delivering services, early identification of vocational goals, small steps in training, and a gradual return-to-work;
- Early intervention programs with strategies for long term self-management of illness, team support from a range of professionals including psychiatrists, psychologists, occupational therapists, vocational advisors, and peer support workers;
- Transitional services that focus on training and guidance that will contribute directly to a person's ability to obtain employment and establish and maintain independence; and
- Access to specialised disability employment services that work in close partnership with clinical services to provide programs for skill development and rapid job search.

3. Government policy-based strategies include:

- Providing stronger incentives to work; and
- Support for education or training providers.

Ways in which service providers may encourage vocational recovery were:

1. Being attentive, responsive, flexible, encouraging, and understanding in providing individualised support;
2. Acknowledging individuals' existing skills and history, and focussing on their strengths, capacities, abilities, and potential;

3. Recognizing individuals as having knowledge of their own recovery from direct experience; Supporting individuals to make informed decisions and take responsibility for them;
4. Creating opportunities with vocation as a central goal of recovery;
5. Providing evidence of successful role models;
6. Influencing employers and the community by raising awareness and improving engagement, and advocating for people with mental health issues, as well as supporting them in advocating for themselves in order to foster more consumer driven and operated services;
7. Facilitating strong partnerships, such as including disability employment services, vocational rehabilitation services, and housing services within the mental health teams and building relationships between service providers and employers; and
8. Remaining open to new and novel forms of employment or volunteering.

Recent changes in Disability Employment Service providers have impacted upon service provision for people with mental illness. With respect to the contemporary context, could you please comment on the following:

1. How do you think services are currently encouraging vocational recovery?

2. What more do services need to do to facilitate this?

3. What resources are required to support this? Are these resources currently available?

4. How have the recent changes in services affected service users' experience of vocational recovery?

Appendix H: Framework for Facilitating Vocational Recovery in Mental Illness Prepared for Service Providers

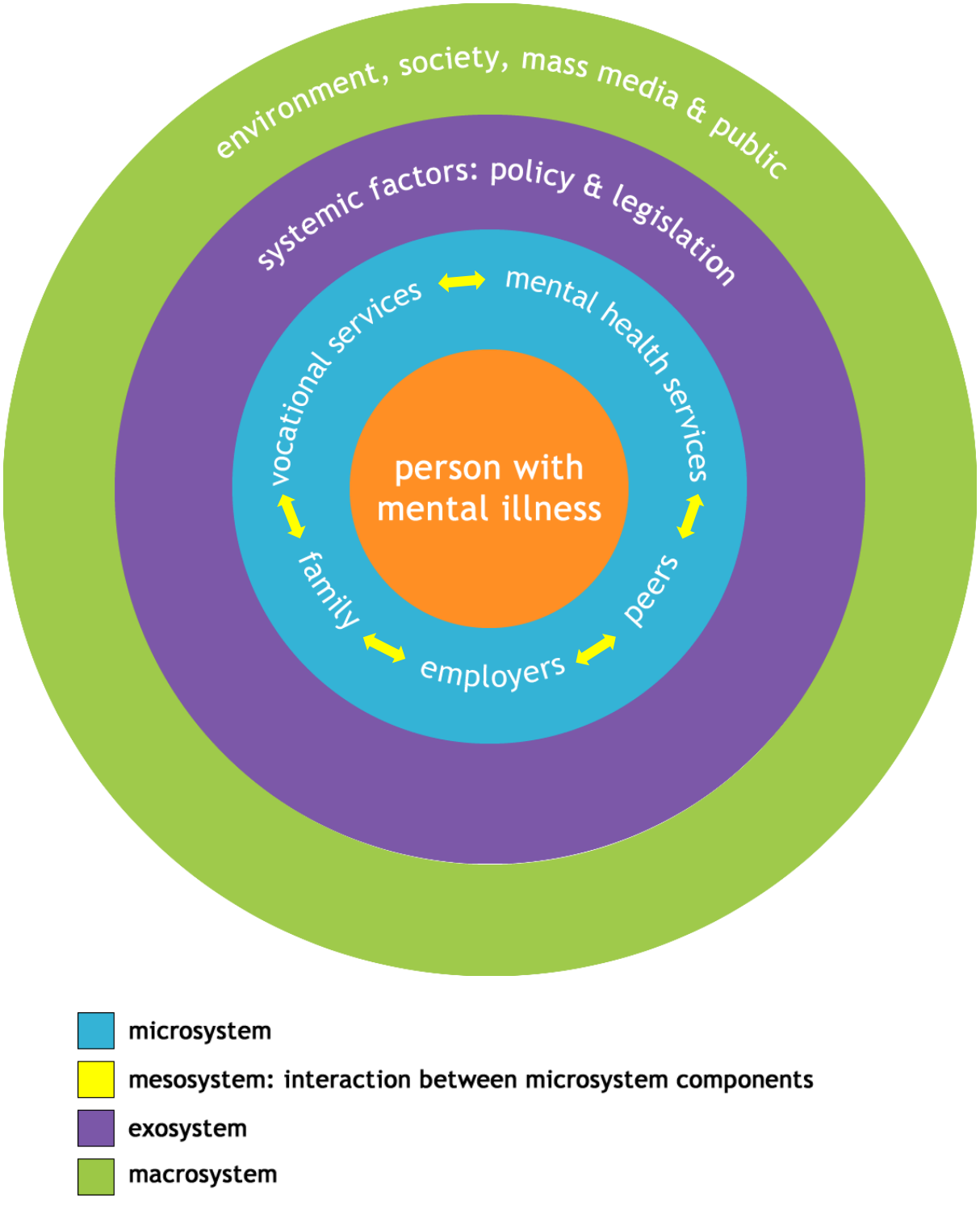
A Framework for Facilitating Recovery in Mental Illness

Vocational recovery involves regaining or establishing a range of valued roles associated with vocation as broadly defined: as a calling, where a person chooses to engage in purposeful, meaningful, enjoyable, and productive activity; feels that the activity is what they are meant to do; and allows them to be authentic or true to their own personality, spirit, or character.

Vocational recovery is complex and holds rich and personal meanings for individuals. There may be different meanings attributed by service providers who may be accountable for outcome measures and may be constrained by the policy and environmental contexts.

An ecological systems approach (Bronfenbrenner, 1977) directs attention to both individual and environmental determinants of vocational recovery in mental illness in the different spheres of a person's life.

Vocational Recovery in Mental Illness Model (based on Bronfenbrenner, 1977)



In describing vocational recovery, the person with mental illness is in the centre of the model, and their personal understanding of vocational recovery shapes their journey through interactions with services and society. A person's

unique life shapes their attitudes, values, feelings, goals, skills, and roles, and vice versa. It is by the process of engaging in vocational activities and interactions that the person comes to make sense of their world and understand their place within it. Ideally, a person should have the opportunity to explore their vocational aspirations. Employment or paid work may be part of a person's vocational recovery journey, which affords the person money for basic things and financial stability. Within structural and societal contexts, people negotiate complex constraints of mental illness and choose to engage with services for personal and vocational support, as well as familial, peer, and social networks. In doing so, they discover (or rediscover) their vocational recovery aspirations and goals. Staying connected and being engaged in life are central in promoting vocational recovery. Dedicated mental health employment consultants who are person-centred in their approach are in ideal positions to facilitate positive vocational experiences for people with mental illness. Service providers are able to connect and develop positive relationships with people with mental illness.

Systemic challenges to vocational recovery exist regarding open employment, rates of pay, transitional vocational preparation, and funding of vocational programmes. Besides addressing these challenges, government policy-based strategies that promote vocational recovery for people with mental health issues include providing stronger incentives to work and support for education or training providers.

At a macrosystem level, societal attitudes and ideologies of the culture determine if challenges such as stigma, prejudice, and discrimination taint a person's experience of vocational recovery. Over time, sociocultural conditions have gradually changed to be more inclusive and supportive of people with mental illness.

Ecological level	**Facilitators that affect a person's vocational recovery**
Individual level:	▪ Keeping well by eating healthily, having a routine,

Person with mental illness	exercising, and being active; ▪ Having balance in life by engaging in meaningful work and leisure activities; ▪ Recognition of symptoms and side effects from medication, and planning for adjustment to changes in medication; ▪ Learning specific life skills to support vocation such as: time and money management, taking transportation, communication skills, and building confidence and self-esteem; ▪ Working towards managing mental health issues specific to returning to the workforce such as social anxiety, fear of change, and lack of motivation; ▪ Being committed to short-, medium-, and long-term personal goals; ▪ Participation in community-based social activities that promote relationships with peers; and ▪ Making a contribution and being a valued member of society.
Mesosystem, incorporating the interactions between Microsystem components: Vocational and mental health services	▪ Person-centred programs that focus on training, education, work experience, and supported employment, namely Individual Placement and Support. Creating a space to grow involves engagement by people delivering services, early identification of vocational goals; ▪ Access to specialised disability employment services that work in close partnership with clinical services to provide programs for skill development and rapid job search; ▪ Early intervention programs with strategies for long term self-management of illness, team support from

a range of professionals including psychiatrists, psychologists, occupational therapists, vocational advisors, and peer support workers;

- Transitional services that focus on training and guidance that will contribute directly to a person's ability to obtain employment and establish and maintain independence; and
- Service provider attributes:
    - Being attentive, responsive, flexible, encouraging, and understanding in providing individualised support;
    - Acknowledging individuals' existing skills and history, and focussing on their strengths, capacities, abilities, and potential;
    - Recognizing individuals as having knowledge of their own recovery from direct experience;
    - Supporting individuals to make informed decisions and take responsibility for them;
    - Creating opportunities with vocation as a central goal of recovery;
    - Providing evidence of successful role models;
    - Influencing employers and the community by raising awareness and improving engagement, and advocating for people with mental health issues, as well as supporting them in advocating for themselves in order to foster more consumer driven and operated services;
    - Facilitating strong partnerships, such as including disability employment services, vocational rehabilitation services, and housing services within the mental health teams and

	building relationships between service providers and employers; and o Remaining open to new and novel forms of employment or volunteering.
Employers	▪ Supportive and inclusive vocational environments, which are free from stigma; ▪ Flexibility of prospective employers and workplaces; and ▪ Mentoring and support.
Family and peers	▪ A familial, peer, and social support network that fosters personal contact and community inclusiveness and is available, accessible, appropriate, inclusive, and flexible; ▪ Good understanding of mental illness by friends, and family; and ▪ Social networks that provide vocational opportunities.
Exosystem: Policy context, that shapes welfare and disability services	▪ Providing stronger incentives to work; ▪ Support for education or training providers; ▪ Sustainable and supportive employment policy regarding open employment, rates of pay, and funding provided for vocational programs; ▪ Mutual obligation – growth comes from challenges and responsibility; and ▪ Financial incentives to work that supplement the disability support pension.
Macrosystem: Environment, society, mass	▪ Good understanding of mental illness by society; and ▪ Free from stigma, discrimination, prejudice, and narrow framings of mental illness.

media, and public